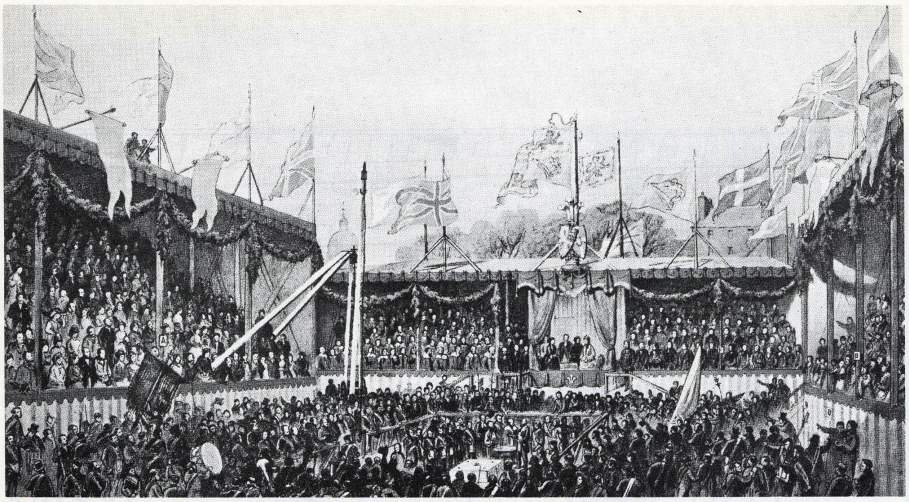

H.R.H. ALBERT EDWARD, PRINCE OF WALES
Laying the Foundation Stone of the New Royal Infirmary, 13th October 1870
(From an old coloured lithograph)

Accounting as a Mechanism of Governmentality in the Creation of a British Hospital System

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Declaration

I declare that this thesis has been composed by me and is entirely my own work.

Acknowledgements

This work has been a long time in the writing. In truth it would never have been completed without the support and guidance of a number of people. Firstly I would like to thank my supervisors Professors Stephen Walker and Falconer Mitchell for their exceptional patience and support when most others would have given up. Additionally they never failed to encourage me and help me to maintain a degree of rigour in my writing. Needless to say, when the rigour fails and the flaws are evident, they are flaws that I made and which even their great skill could not overcome. Thanks in particular to Steve Walker for introducing me to history, as both a subject and a mode of research that has given me much joy over the years. Many other friends and colleagues, too numerous to mention here, have also given great encouragement over the years. Thanks to them all.

Of course I cannot fail to mention my family here. They have been a rock for me through minor successes, major failures, extended vacillations and significant illness. Thanks then to Audrey, my wife, and Amber and Jade, my daughters, for putting up with me when at times it must have been hard. Thanks also to my Parents Elsie and Bill and in particular to my father who encouraged me to begin this venture even when he was terminally ill. This thesis is dedicated to him.

Abstract

This thesis is historical in nature. It adopts a methodology that has recently taken the study of accounting history into the arena of the social; leaving behind traditional notions of accounting as being only what accountants do. The focus of the study is on the annual reporting of activity, in terms of both its financial and physical dimensions, in the history of the British voluntary hospital movement. The study is highly contextualised. By adopting this approach it has been possible to show how accounting reports initially enabled the managers of medical institutions to reverse the focus of accountability onto those charitable individuals that were providing the funding for the hospitals. This greatly strengthened the fundraising capacity of the hospital, while simultaneously deflecting attention away from the efficacy of the institution itself. Later, however, it is shown that after various abortive or only partially successful attempts, it was possible, through the medium of a uniform accounting system, to return the focus of accountability back onto the management of the hospitals. It is important to note that the success of this movement was contingent less on the quality or viability of the accounting system than the legitimacy of the organisation that published its results. Until this legitimacy was established in the minds of the users of the accounts the effects of the accounting was severely limited. Once it was firmly established the accounts became a powerful knowledge technology that enabled a substantial degree of control to be exercised over hospitals, such that a 'quasi-system' of hospitals was created.

CONTENTS

LIST OF TABLES

LIST OF FIGURES

1. INTRODUCTION

The matter discussed in this thesis is located in the history of accounting. Histories of accounting and accountancy have become increasingly prevalent in recent years to such an extent that history as a mode of research has escaped the view that it was essentially an antiquarian pursuit with little relevance to the mainstream accounting research community. For instance, Brown's citational analysis of the 100 most influential accounting articles of all time, found four historical studies in the top 100 and two in the top 10 (Brown, 1996). This reflects the awareness of a substantial section of the research community that historical approaches can offer insights into the worlds of accounting that cannot be attained by other methodologies. Such insights can go beyond the assertion that those that ignore the past are doomed to repeat it. The best accounting history, (such as those studies identified by Brown), seeks not simply to identify past mistakes in order to prevent their reintroduction into contemporary practice, but rather takes us into territory that penetrates and disrupts our current understandings of what accounting is, where and why it is practised and, how it came to achieve its present status in our social order (Miller et al., 1991). This thesis aims to contribute towards that project by practising the analysis of accounting history in a similar vein.

One of the great achievements of recent historical and critical accounting is to broaden the scope of accounting research, taking exception to the idea that accounting is just what accountants do and developing the concept of studying accounting in the contexts in which it operates (Burchell et al., 1980: Miller et al., 1991: Miller, 1994). The result is an expanded arena for research that sees beyond the confines of company financial reporting and factory cost and management accounting into an understanding of accounting that offers the breadth of social institutions as a location of accounting practice. One such location is that of the hospital. Despite the existence of much contemporary research that examines the situation of accounting in health care the relative lack of historical analyses, especially in the UK, is notable. Only a small number of studies exist in this area and, as a result, the development of accounting in the hospital, particularly in the 19th century is largely unexplored. This study will make a contribution towards resolving the deficit.

The 19th century was a particularly interesting time in the history of accounting. In the latter half of the century we see the emergence of accountancy as an organised profession initially in the Scottish cities and, subsequently in England (Walker, 1995, 2004c). In addition to this we see early attempts to create statutory audit and corporate reporting with the growth of limited companies and throughout the century management accounting was deemed to be in a state of rapid evolution and change (Johnson and Kaplan, 1987). Some have argued that most of the change was sponsored by economic development while others have seen that

much of 19th century accounting arose from emerging social philosophies such as utilitarianism (Gallhofer and Haslam, 1994b,a, 1996, 2000). In any event it was a time of great economic, technological, social and political change; a highly dynamic environment where accounting was both transforming and transformed by the contexts in which it was located. This thesis will show that it was no less true for accounting in the hospital sector than it was for any other arena of British economy and society in the 19th century.

Throughout the 19th century the British hospital sector became increasingly complex. The voluntary hospitals, the great charitable institutions that began to be founded in the 18th century, were becoming numerous and competing with each other for limited charitable funding at a time when increasing populations were putting pressure on their ability to cope with rising numbers of sick poor. As part of their responsibility towards those that donated the charitable funding for the hospitals the committees of management published annual reports of their activities. These reports were remarkable, both for the time of their origins in the 17th century and, later, for their scale, often running to hundreds of pages. It is these annual reports and the practice of annual reporting that is the main subject of this thesis as it examines the conditions of emergence and uses to which these reports were put. The thesis adopts a broad Foucauldian stance, considering that the annual reports of the hospitals were documents that allowed interested groups to gather knowledge and use it in the exercise of power, both on groups inside and outside the hospitals.

The thesis has two main parts to it. Initially, in chapter 3, it will show how the managers of one of these voluntary hospitals, the Royal Infirmary of Edinburgh, were able to take information that the contributors of funding wished to see in the annual reports of the hospital and use that information to bring pressure to bear on the contributors to increase their contributions to the hospital. Then in chapters 4, 5 and 6 the thesis will examine attempts by a loose collection of reformers to construct a system of organising the hospitals with uniform accounting at its heart. This was done to bring order, economy and efficiency of management and coordination to the hospitals of London, using the reported accounting information that the hospitals supplied.

Each chapter will examine successive iterations and attempts to create this organisation, examining the factors that contributed initially to the failure and ultimately to the success of the movement. The next chapter will examine the position of this kind of research in the historiography of accounting and will show how this thesis will fit within and contribute to that historiography. Within the chapter a theoretical stance will be established.

2. TOWARDS A HISTORY OF ACCOUNTING IN ITS WIDER SOCIAL CONTEXT

2.1 Introduction

> "A lot of wasted effort occurs in historical research because researchers spend time analyzing archival records, but fail to find a problem, or fail to find the answer to a question. In such cases, the researcher apparently writes up a description of the material examined, comes to the startling conclusion that old accounting records are interesting and/or different from modern records, and then mails off the manuscript to an editor. Such descriptive results are not of historical and literary significance." (Flesher and Samson, 1990, p2)

The above quote from Dale Flesher and William Sampson in their first issue as editors of the *Accounting Historians Journal* reflects not only their disappointment with the quality of manuscripts that they had received but a recognition of the changed nature of historical accounting research and its position within the accounting research hierarchy in the US. Once regarded as the preserve of those who would pursue their typically antiquarian researches solely for the interest of themselves and those others who take pleasure in dredging up 'interesting facts' about the development of accounting techniques and professional accounting organisations, accounting history has undergone a transformation. What was labelled as the 'new' accounting history became an approach to research which was and remains responsible for entirely new perspectives on accounting; perspectives which

have challenged more than just established ideas of accounting, they also attacked the very foundations of traditional accounting research methodology. This for a while placed the accounting history in a dichotomised position: admired by those who were impressed by its ability to create original interpretations of the nature and purposes of accounting, but distrusted by others who question its methodologies and the motives of those who carry out the research.

The next section of this chapter will examine the process by which this dichotomy arose and will argue that, the only practical way forward is to agree on paradigmatic diversity, allowing deeper exploration of existing perspectives and the ability to accept, (after critical assessment), the adoption of new ones. With this approach, the new accounting history can continue with full force the movement which gave it prominence in the first place; the expansion of the accounting research agenda into new and diverse areas of the social world.

The third section of the chapter will move towards an examination of the potential which has been demonstrated by the work of those researchers who have begun to explore the non-commercial setting of historical accounting practice. Continuing along this line section four will discuss the reasons for adopting the history of accounting within the context of British voluntary hospitals as a worthy way of beginning a history of accounting in social welfare and will review the literature that exists in this area. Section five will explore the Foucauldian concept of Governmentality as a theoretical framework for this study and section six will discuss

the sources that will be used in the study.

2.2 The Changing Nature of Accounting History

2.2.1 Antiquarianism

Research into the history of accounting is not a recent phenomenon, with works by Worthington (1895) , Brown (1905) and Littleton (1933) providing early examples and the launch of the *Accounting Historians Journal* (AHJ) in 1974 demonstrating the demand for an outlet for this kind of work. However, most early accounting history work, including that which appeared in the early issues of AHJ, was either highly antiquarian in nature, or inclined towards the production of eulogising biographies of the 'good and the great' of accounting and/or of the professional accounting bodies (see for example Byrd 1974) . An antiquarian approach towards the history of double-entry bookkeeping was particularly sponsored by the work of Werner Sombart (1924) the German economic historian who argued that double entry bookkeeping was a necessary condition for the rise of capitalism[1] . This led to a long running debate over whether double entry was really necessary (Yamey, 1949), and whether it had emerged at the same time as capitalism (see for example, Most 1972, 1976, Lee 1973a, 1973b, Nobes 1982, Hernandez-Esteve 1994) with another wave of such material published on the 500th anniversary of Pacioli's publication of the *Summa de Arithmetica* in 1994 in special issues of both AHJ and

[1] The reader of the antiquarian work surrounding the Sombart thesis could be forgiven for believing that Sombart was a great advocate for double-entry bookkeeping and capitalism. However, despite his apparent admiration for the effectiveness of double-entry, Funnell's paper (2001) points out that Sombart despised capitalism and sought to return Germany to a more medieval, rural society. The fact that this view never surfaces demonstrates the narrowness of antiquarianism

Accounting, Business and Financial History (ABFH). Due to the nature of much of this research and perhaps because of the dominance of the hypothetico-deductive model in mainstream (particularly US) accounting research (Chua, 1986) historical data was seen as both unsuitable and irrelevant to 'useful' accounting research until the 1980s.

2.2.2 Towards a New Accounting History

In the 1980s however, the perceived usefulness of historical data to 'serious' accounting researchers had begun to change. In 1980 a seminal article was published in *Accounting, Organizations and Society* (AOS) entitled, *'The Roles of Accounting in Organizations and Society'*, in which the authors pointed out that '[accounting] has developed into an influential component of modern organizational and social management ... [It] can no longer be regarded as a mere collection of techniques for the assessment of individual economic magnitudes' (Burchell et al., 1980, p5-6). They further claimed that '[Accounting] now functions as a cohesive and influential mechanism for economic and social management ... [but] very few attempts have been made to probe into the rationales for the existence and development of accounting itself' (p6). After a broad discussion of the organizational and social roles of accounting the authors concluded that, 'once implemented, an accounting becomes an organizational and social phenomenon, there to be used for a variety of ends by a range of actors in an organization.' (p22) To explore these issues they identified, 'a real need for more historical studies of the development of accounting.

Just how has accounting come to function as we now know it? What social issues and agents have been involved with its emergence and development? How has it become intertwined with other aspects of social life? And what consequences might it be seen as having had?' (p23) This call moved accounting history to the forefront of a new research agenda; one which would critically and dramatically question the neutrality and functionality of accounting and accountants.

2.2.3 Changing Perspectives

In the 1980s the idea of the accountant as a neutral reporter, using scientific measurements to map the financial position of businesses and provide objective and value free tools for the use of management (Solomons, 1991) came under attack by researchers using historical data on at least two broad fronts. Firstly, the idea of professional accounting organisations and their members as selfless servants of society was debunked by researchers using sociological models of professionalisation. By examining the formation of professional accountancy bodies in the UK, and particularly in Scotland, researchers were able to demonstrate that, far from being motivated by altruism, desires such as collective social mobility, occupational closure and also threats from legislative challenges to the right of accountants to carry out certain forms of work, especially bankruptcy, were the prime reasons for professional formation, (MacDonald, 1984, 1987: Briston and Kedslie, 1986: Willmott, 1986: Walker, 1991, 1995: Walker and Shackleton, 1995: Walker, 2004c,d,a: Edwards et al., 2007). Building upon this, a significant volume of work has emerged that

questions the attitudes of accounting organisations towards issues of ideology, gender and race[2], thus significantly changing our perceptions of these bodies. Secondly and in like fashion, critical studies of accounting practice, particularly management accounting practice, have also challenged ideas of neutrality and functionality and have led to the emergence of three major paradigms, sometimes described as a 'trichotomization' of accounting history (Fleischman et al., 1996a).

In 1986 and 1987 a series of accounting history articles were published in AOS four of which were ranked by Brown's (1996) citational analysis, as being amongst the top fifty most influential accounting articles of all-time. All four of these articles were based on the work of the French social theorist Michel Foucault and focused on the power of accounting as a disciplinary technology. Despite their common theoretical standpoint the four papers explored diverse areas of accounting. Firstly, Hoskin and Macve (1986) considered the emergence of accounting from the examination regimes of medieval universities and the transfer of this regime of control through education to students of the West Point military academy in the United States who then applied it in commercial enterprise later in their careers. Then, Loft's paper described the emergence of costing systems during World War I as a consequence of governmental intervention to prevent profiteering (Loft, 1986).

[2] For example on resistance to the admission of women to the accounting profession see (Shackleton, 1999: Carrera et al., 2001), on accounting as a way of reinforcing gender stereotypes (Walker, 2003c,b: Walker and Carnegie, 2007) on race in the accounting profession (Hammond, 1997: Annisette, 2003), on the attitudes of the profession towards Nazism (Walker, 2000) and indigenous peoples (Preston and Oakes, 2001: Davie, 2000: Annisette, 2000: Walker, 2003a: Preston, 2006). Also, for recent studies of the professionalisation process in other countries see (Ramirez, 2001: Carnegie and Edwards, 2001: Everett et al., 2005: Bakre, 2005, 2006: Sian, 2006: Varma and Gray, 2006: Dedoulis and Caramanis, 2007: Dyball et al., 2007)

Thirdly, Hopwood used Foucault's archaeological analysis on three examples of accounting change to discuss the preconditions, process and consequences of accounting change and to show that accounting should not be treated as an isolated craft or technology, but as part of a broader socio-political and economic context (Hopwood, 1987). And finally, Miller and O'Leary's analysis of early 20th-century standard costing and budgeting as part of an apparatus of power, a 'technology of government', within which the individual was seen as a manageable and efficient entity (Miller and O'Leary, 1987). This rendering of accounting as a disciplinary technology within a power-knowledge framework was a radical departure for historical accounting research, but this new theory of accounting was neither alone nor unchallenged.

Accounting historians working from a more traditional economic perspective had been stimulated to create their own paradigm of accounting by the work of the business historian Alfred Chandler. In two books on industrial history Chandler drew the attention of accounting historians to the importance of cost and management accounting in the rise of the giant industrial organisation (Chandler, 1962, 1977). Johnson was inspired to adopt this viewpoint as a basis for research upon the emergence of cost accounting at a mid nineteenth-century cotton mill (Johnson, 1972, 1983) and later to collaborate with Kaplan on *Relevance Lost: the Rise and Fall of Management Accounting* (Johnson and Kaplan, 1987).

The publication in 1987 of *Relevance Lost* had a major impact on the progress

of accounting history; 'bring[ing] accounting history into a central position both in terms of the research agenda and in terms of practical business management' (Loft, 1995, p30). Johnson and Kaplan located their study within the rise of giant commercial organisations in the US; from textile mills through railroads and chain stores to chemical corporations and beyond. Placed in Chandler's framework they came to view management accounting as a product of the needs of increasingly complex industrial organisations to generate information that 'evaluate[d] a company's internal processes' (Johnson and Kaplan, 1987, p42) thus ensuring that the cost of administration did not outweigh the benefits to be gained from the organisational form, an idea based upon Williamson's transaction cost theory (Williamson, 1975). This places management accounting at the heart of the rise of the industrial organisation, since without the information generated by the accounting system the companies would never have been able to attain their great size and complexity. However, their claim that the modern focus of costing had moved from cost management to cost accounting for the purposes of inventory valuation in the financial statements and had thus lost its relevance for management, did not pass unchallenged. Rather it simply highlighted the underlying view of the authors, that management accounting should be a tool of management in the search for greater efficiency and profit maximization.

Johnson and Kaplan's concept of accounting as a tool for managers in the pursuit of efficiency was directly challenged by those who felt that accounting impinged more directly on human activity than was suggested by *Relevance Lost*,

not least by the Foucauldians (Ezzamel et al., 1990), but also by the proponents of the Marxist school, the third major paradigm in the new accounting history. The initial attack by Tinker and Neimark was on the transaction cost theory, arguing against its dominance as a motivating force:

> "[it] is not to say that cost reduction is not a motivating factor. Of course it is. What we are saying is that cost reduction is neither the only strategy employed by capital nor is it is socially neutral one" (Tinker and Neimark, 1988, p57)

Then, going further in their riposte to *Relevance Lost*, Hopper and Armstrong (1991) offered an alternative analysis of management accounting as a tool of capitalists, used to control and intensify the effort of the individuals working in the factory. This school of thought is based on the argument forwarded by Braverman that the capitalist has excellent control over capital, through his ability to locate it within the entity and by the methods of allocation and depreciation within the accounting system, but that labour outcomes are far from certain (Braverman, 1974). Thus, the purpose of management accounting techniques is to gain control over the labour process and exploit its output to the maximum, with little or no regard to the welfare of the individual employees concerned.

2.2.4 The New Agenda

Perhaps the most significant outcome of these emergent paradigms was the way in which they have brought a new conception of what accounting is and how it engages with the social and economic context in which it operates. In the space of a few

years these and other historical studies of accounting have permanently changed the understanding, scope and range of topics available to accounting researchers and have demonstrated ways in which accounting research can inform and influence debates in the wider social sciences. Miller (1994, p. 27) elucidates:

> "A distinctive research agenda has recently emerged within accounting. This novel agenda, based as it is on the study of accounting as a social and institutional practice, broadens and extends existing concerns with accounting in its organisational and social context. The numerous appeals to study accounting in action in specific organisational settings are reinforced. But there is a further injunction: to move beyond organisations to include the social and institutional matrix within which individual organisations seek to innovate."

Arguably, it is this broadening and expansion of the agenda which is the greatest achievement of the new accounting history. New questions are posed, new issues considered and the definition and scope of what is considered to be accounting and of its relevance to society has been changed beyond all recognition by the efforts of the new accounting historians. However, this effort has not entirely been conducted in a spirit of co-operation between the different schools of thought. While new research continued to emerge, significant effort was expended by proponents of one paradigm or another attacking the positions of those who support other schools. These attacks were been prolonged and detailed and led researchers to look inwards at the theoretical underpinnings of each position, as they tried to demonstrate the superiority of their methodology and the inferiority of that of others. This effort, while worthy, arguably distracted attention away from the expansion of the accounting research agenda and led to insular infighting amongst

the relatively small group of historical accounting researchers. The next section will examine the debate.

2.2.5 The Historiographical Debate

Understandably, due to the predominance of such assumptions in historical and other accounting research, the early attack centred upon the way in which 'our appreciations of the technical nature of accounting are infused by a rhetoric of economic and managerial rationality and functioning' (Hopwood, 1987, p210), because, 'rather than providing a history of the emergence of accounting as it now is, they provide the basis for the compilation of a history of inadequacy, ignorance and obsolescence when accounting was not what it should be, peppered with only occasional moments of enlightenment when accounting moved nearer to realising its potential' [p211]. Subscribers to traditional accounting history were pressed further when it was claimed that, 'it is inadequate to attempt to explain the significance of accounting in modern society by identifying any clear link between its use and the improvement of 'rational economic decision taking" (Hoskin and Macve, 1986, p105). 'Such histories' argued Miller and O'Leary 'tend to limit themselves to either a detailed and careful chronology of ideas and techniques, or to a narrative ... in which ... the history of accounting becomes the unfolding of a socially useful complex of techniques, whose underlying logic is one of progress (Miller, 1994, p98). Similar criticisms were turned upon the work of Johnson and Kaplan: 'although this [*Relevance Lost*] is an interesting line of research ... it does not go far enough,

for the writers tend to concentrate on the accounting-organisation relationship and pay only scant attention to the broader social context' (Loft, 1986, p138). Hopper and Armstrong were even more forceful when they said 'their theory is flawed, their history partial and some of their prescription neglectful of the socio-economic conditions of which the achievements of the 1920s depended' (Hopper and Armstrong, 1991, p406). The increasing number of attacks and the combative style of the language used by the critical researchers inevitably drew responses from those working within the more traditional archival based research method. Significantly, the early debate between Hoskin and Macve (Hoskin and Macve, 1988b,a, 1994) and Tyson (Tyson, 1990, 1993), over the genesis of managerialism in the United States[3], highlighted not so much the differences between the different explanations inherent in the opposing paradigms, but the fundamental opposition of the traditionalist Tyson to theory driven research methodologies.

Tyson's premise was that those adopting an explanatory theoretical framework could and would select and manipulate the 'facts' in order to conform to the model that they were using (Tyson, 1993, p4). Arguing that the 'facts' could be twisted to fit any theoretical model, he neatly summarised his position with the following quote from Arendt: 'the trouble is that almost every axiom seems to lend itself to consistent deductions and this to such an extent that it is as though men were in

[3] The debate has run on for years and enlarged to include similar developments in the UK, during the Industrial Revolution and beyond, and to an examination of the reasons for the chronological differences between the emergence of cost accounting practices in these two locations (Boyns and Edwards, 1996: Hoskin and Macve, 1996: Boyns and Edwards, 1997b,a: Boyns et al., 1997a,b: Fleischman and Parker, 1997: Tyson, 1998: Hoskin and Macve, 2000: Fleischman and Tyson, 2000)

a position to prove almost any hypothesis they might choose to adopt' (Arendt, 1968). Accusing the theoretical historians of crossing the boundary from history into philosophy, Tyson complained that 'philosophers have no commensurate obligation regarding the nature of an investigation, the selection of factual material, or the concern with appropriate evidence. While it may be perplexing to distinguish between fact, opinion, and interpretation, the historian has an implicit obligation to try' (Tyson, 1993, p6). It is this last that reveals the nub of the problem for the traditional historian; their belief that an examination of the facts can and will reveal the historical truth, while studies less rigorously bound to the archive will only produce dogmatic distortions of that truth. This view is grounded not only in an understanding of what it is that constitutes reliable historical evidence, the 'facts', but also, and more fundamentally, in the perceptions and convictions that the historian holds over the nature of the world in which he or she lives. For Tyson, the data that he had culled from the archive would reveal the 'truth' of his position and expose the falsity of the Foucauldian dogma. This 'truth' was utterly refuted by Hoskin and Macve (1994) who, by reference to sources of evidence outside of Tyson's archive, were able to demonstrate, (although not to Tyson's satisfaction at that time (Tyson, 2000)), the narrowness of his perspective.

As critiques of the explanatory power of the various models failed to shake the faith that the proponents of those models had in them, the critics increasingly turned to examination of and attack upon the philosophical foundations of the actors involved. As the debate became more intense, historiographical papers which

explored the potential of accounting history (Napier, 1989: Previts et al., 1990: Merino and Mayper, 1993: Parker, 1997) gave way to a growing number of papers that attempted to summarise and clarify the positions of the protagonists (eg. Stewart 1992). Carnegie and Napier stylised the nature of the debate with their caricatures of the 'traditional' and 'new' historians:

> '[the] "traditionalist" who decontextualizes accounting, who celebrates progress and thereby subtly denigrates the past, explains everything by reference to neoclassical economics, who at worst sets out on a "treasure hunt" merely to establish the oldest, the earliest, the strangest, at best views the past entirely from the perspective of the present. On the other hand, ... the "new accounting historian" is one whose history is written through the verbiage of obscure theorization, who eschews evidence for speculation, who "writes to a paradigm"' (Carnegie and Napier, 1996, p8).

This view of the new accounting historians, whilst admittedly containing 'much exaggeration' (p8) did contain the kernel of one of the major disagreements between the new and traditional historians, namely the nature of what it is that constitutes historical evidence. The conviction of Tyson and other traditionalists that the truth could be found in the archive and the equally strong conviction of Hoskin and Macve and the new accounting historians that such truths derived from archival sources could be defeated by contextualisation through what the traditionalists regarded as secondary sources, had provided the focus upon which the battles had been fought. At the turn of the century, however, there were signs that the historical commmunity would begin to reconcile.

In 2000 Richard Fleischman (Fleischman, 2000: Fleischman and Macve, 2000: Fleischman and Radcliffe, 2000) became more accepting of the ideas and explana-

tions generated by alternative paradigms than he was earlier, (although he appears to wish to combine their explanatory power, rather than except any one model as being superior). Fleischman has suggested reasons for reconciliation as diverse as greater explanation through paradigmatic combination (1996a, 2000a,b), strength through unity against the common enemy of mainstream accounting research in the US (2000c) through to an appeal that the division of accounting history into traditional and new is no longer helpful and that accounting historians should be fair-minded to their opponents (Fleischman et al., 1996b: Fleischman and Radcliffe, 2003)[4]. Working on a different tack, others sympathetic to the ideal of unity amongst accounting historians, have suggested the use of narrative as a way in which researchers can find common ground.

Identifying loosely with Fleischman's notion that disunity amongst accounting history researchers weakened their ability to attack the positivist mainstream, Funnell (1996) identified 'the opportunity in accounting history to promote a community of scholars pursuing a plurality of approaches where the aim is critical, synergistic co-operation rather than carrion competition' (p39). 'Recent research' he added 'makes it very clear that there is still the opportunity for all but the more radical new social accounting historians to find common ground with the traditional accounting historians' (p43). Funnell's argument is that despite the implacable hostility between traditional and postmodern historians in general history, 'it is important to be reminded that postmodern views of historical reality are not

[4] Ultimately even Tyson began to give ground to the new historians (Tyson et al., 2005)

yet an established feature of new accounting history' (p53). This combined with an apparent acknowledgement from traditionalists that interpretation is a factor even amongst archival researchers, the old and new accounting histories are much closer together than the acrimonious debate would have suggested. The way forward suggested Funnell was to focus on the use of narrative because, 'at present, both traditional and new accounting historians continue to find common ground with the narrative form and its epistemological attributes, despite criticisms by some new accounting historians' (p58), an approach supported by Poullaos (1998). Funnell backed this up with a second paper in which he argued that even postmodern historians regularly use the narrative form in what he termed 'counternarratives' (Funnell, 1998). With this common use of narrative, he argues, both traditional and new accounting historians can, at least until narrative comes under more serious attack from within the accounting community, find common ground on which to meet.

Still others have given an opinion in favour of paradigmatic historiography (Chua, 1998: Gaffikin, 1998: Merino, 1998: Boyns and Edwards, 2000) and of the pluralisation of methodologies envisaged by Miller et al (1991). Barbara Merino argues that 'critical historical studies have the potential to make significant advances in understanding our discipline ... To do this, we have to change the tenor of our rhetoric and not fall into the modernist trap of trying to find a "certified path to truth" ... Let's simply acknowledge that all researchers, including historical researchers, view the world through some lens and that we will have a better and

more productive dialogue if that lens is made explicit and open to debate' (Merino, 1998, p633). Hoskin and Macve would now appear to consider that this attitude is a fait accompli when they write that 'the new conventional wisdom is that plurality of conceptual perspectives, research questions, and methodologies is now to be regarded as a sign, not of intellectual weakness, but rather of both the maturity of accounting history and of its consonance with the state of social science research and wider historical research' (Hoskin and Macve, 2000, p128). For those who perceived the rift between accounting historians as damaging, an acceptance of the pluralisation of methodologies seems to have achieved, in the last few years, an air of calm and the efforts of accounting historians have been redirected towards that which brought accounting history to prominence in the first place; the expansion of the accounting research agenda (Napier, 2006).

2.3 New Directions in the Accounting Research Agenda

Although it is impossible to deny the success of the new accounting history in expanding the research agenda, much of the early work focused on the nature of accounting within business organisations. This perhaps is strange, because one of the key elements of the new perception of accounting is that it is not just a technical practice in the employ of management for decision making purposes, but is rather 'a pervasive and highly generalised technology that can contribute to the functioning of a very wide range of organisations and socio-economic processes'

(Hopwood, 1994, p299). As such we can expect to find it embedded in all levels of society from governmental organisations through to more humble organisations, such as homes, clubs, voluntary organisations and so on. This embeddedness of accounting in the huge diversity of social organisations has been something that, with some notable exceptions, has has only recently begun to be seriously explored in accounting history.

In recent years a few researchers have begun to escape from the commercial setting of historical accounting research. Notably, the work expanding upon Hopwood's theme of accounting and everyday life (Hopwood, 1994) has shown the extent and depth to which accounting practice is an integral part of our everyday existence (Walker, 1998, 2003c: Llewellyn and Walker, 2000: Kirkham and Loft, 2001: Jeacle, 2003, 2006, 2009). Further examinations of the non-commercial aspects of accounting's social context are taking place (Komori and Humphrey, 2000: Froud et al., 2000: Lamb, 2001: Suzuki, 2001) but these studies remain relatively few and far between. As a result, enormous potential still exists in exploring the history of social aspects of accounting in a non-commercial setting. One such study that has parallels with this work is the paper by Walker looking at the administration of poor relief in 19th century England (Walker, 2004b, 2008). The examination of the way in which the economy of relief and the management of the poor themselves indicates a form of social institution with many similarities to the type understudy in the current work: the hospital, an area that has only recently begun to be explored in any detail by accounting historians.

2.4 Accounting in the History of the Hospital Sector

Few will argue the importance of medical provision to contemporary society or its importance as a function of the British state. At the centre of this enormous and complex system are the general hospitals; typically, vast Victorian structures which once dominated the skylines of most of our large cities. These hospitals are the remnants of the old voluntary hospital system incorporated into the National Health Service in 1948. But, even before this time these institutions were vast and important structures in our society; often the focus of civic pride and regularly amongst the largest buildings of the 18th and 19th centuries.

From an accounting historians point of view, one of the interesting features of these hospitals is the fact that typically if not universally they published annual reports. While this may not seem all that startling in itself it becomes more so when we realise that this practice occurred early in the 18th century and continued right up to the point of formation of the NHS. This study will attempt to analyse the practice of this reporting in the context of the development of these great hospitals in order to explore the relationships that were established around this familiar accounting practice in this most unfamiliar social setting.

2.4.1 Hospital Accounting History

In common with other areas of welfare organisation, there is a poverty of historical research into hospital accounting. The handful of studies that do exist are scattered across the spectrum of historical hospital accounting, variously in terms of location, content, chronology and perspectives employed. Van Puersem et al (1996) considered the importance within the last two decades of annual reports within the New Zealand health sector to public funding decisions and attempted to suggest some improvements to the practices employed. More descriptive is Lacombe-Saboly's explanation of 17th and 18th-century French hospital accounts (Lacombe-Saboly, 1997). Adopting a position typical of the traditional accounting historian, Lacombe-Saboly assumes the trajectory of accounting improvement when he claims that 'in the seventeenth and eighteenth centuries the accounting method in the three archives studied was basic' and 'weakness in the areas of economics and finance appears to have been widespread among hospital managers' (p265). A major change in the nature of hospital accounting is identified when 'with the [French] Revolution, hospitals were incorporated into public ownership; ... [and] for the first time, a hospital accounting system was put in place' (p274). However, despite the introduction of a standardised system, hospital accounting was still held to be 'basic', because, 'the needs of the state for accounting information did not take into account the value of the public patrimony, and so did not bring about the development of debtors, creditors or property accounts, unlike the

private businesses of merchants' (p 276). Thus, the significance of the imposition of a standardised accounting system by the state and its effects on French hospitals is simply ignored by this study as it is deemed not to have 'improved' the system of accounts in operation in French hospitals. Seville describes the attempts to introduce generally accepted accounting principles (GAAP) to voluntary health and welfare organisations (VHWOs) in the period 1910 to 1985 (Seville, 1987). Seville's managerialist perspective criticises the 'problems [that] still exist' in VHWO accounting and claims that 'despite the improvements which have occurred in VHWO accounting, accounting, research is still needed to make accounting and reporting for VHWOs useful to internal and external decision makers' (pp76-77). Thus, the assumption that the accounts exist for decision-making purposes, precludes the possibility of a contextual analysis that may reveal alternative reasoning behind the accounts of voluntary health and welfare organisations.

On a different tack, Amanda Berry's study of the methods employed by hospital governors to manage the finances of three English provincial voluntary hospitals between 1765 and 1815 employs a utilisation of information contained within the hospital accounts, rather than an analysis of the accounts themselves (Berry, 1994, 1997). Discussion centres around the techniques employed to balance receipts and disbursements, such as fund-raising activities cost-cutting measures. No attempt is made to consider the role that the hospital accounts may have played in influencing the circumstances of the hospital. Indeed, it is assumed that the accounting information is neutral, demonstrated by the fact that Berry has deconstructed the

accounts and reassembled them according to the plan laid out in the Uniform System of Hospital Accounts published by Henry Burdett in 1893[5] (1994, p4), with an expectation that this would have no effect on the analysis.

Still on the theme of voluntary hospital finance is Steven Cherry's work on the attempts by some trade associations to gain managerial influence in voluntary hospitals through the strength of their financial contributions to them (Cherry, 1996a,b). While it is 'accountability' rather than accounts that Cherry examines here the work is interesting for the way that it introduces a more critical view of the contextual influences upon the management of the hospital. For instance, he points out that 'assumptions concerning grateful patients or compliant bands of hospital workers, subordinate to hospital or medical authority, require modification' (p231) suggesting that voluntary hospital management was subjected to often conflicting and competing demands by different groups. Thus he argues, patients contributory funds and other contributory funds were able to gain access to the management of the institution.

More relevant to this study perhaps, are Preston's piece on the 'Emergence and Transformations of Discourses on Costs of Practices of Accounting in US Hospitals' (Preston, 1992) and the work by Jones and Mellet and by Robson on the historical development of accounting practice in the health service (Jones and Mellett, 2000:

[5] This was the first publication of *The Uniform System of Hospital Accounts* although Burdett had first devised his system with the assistance of two colleagues at the Queens Hospital in Birmingham much earlier in 1869. A further two editions were published by Burdett in 1906 and 1920 and the work remained the standard for hospital accounts during this period, as well as providing the basis for later revisions by other authors after Burdett's death in 1921.

Jones and Mellet, 2007: Robson, 2003, 2007). Firstly, as a result of its analysis of the way that US hospital accounting practice is constituted by the accounting discourses of the time, Preston's study strongly highlights the socially constituted nature of accounting within US hospitals, however, it is weaker in its examination of the way that accounting, in turn, helps to constitute the environment around it. This problem can also be detected in the work of Jones and Mellett as they chart the development of 'a primarily communitarian health service ... in which accounting played a passive, supportive role ... through [to] the institutional framework of the NHS, [which is] primarily based on etatist-inspired market principles' (2000, p13). Unfortunately, Jones and Mellett's analysis fails significantly in its understanding of 19th-century hospital accounting. This may be mainly because they have tried to examine two hundred years of hospital accounting in a single study, but more fundamentally, their reliance upon a handful of sources in their discussion of 19th-century accounting has led them to a misunderstanding of the nature of the voluntary hospital system as essentially communitarian. Robson (2003, 2007) has also examined the development of accounting in UK hospitals with an examination of the emergence of the department and drivers of accounting change, between 1893 and 1956 and the attitudes of the Newcastle Infirmary towards the Victorian sick poor was examined by Holden, et al (2007). Finally, Robbins and Lapsley (2008) examined a case of failure in the Irish voluntary hospital movement.

As can be seen, there are relatively few historical studies which exist in the area of hospital accounting. Those that do exist are either relatively descriptive,

traditional style pieces like the studies of Lacombe-Saboly and Seville which fail to bring the social context to bear on an analysis of hospital accounting, or, in the case of the papers by Berry and Cherry, consider financing arrangements, which, although not irrelevant do not engage directly with the hospital accounting systems. Alternatively, where the social context has been brought to bear on the accounts it has been done only partially so that in Preston's work he examines only the impact of the environment on accounting and not the converse impact of accounting on its environment. The other studies touch on the subject of voluntarism but either consider it from the end of the 19th century, skim over it, or consider issues of failure or attitudes towards the sick poor.

Given the scale, importance and its ongoing significance to British society, the attention devoted to the hospital sector by accounting historians has been minimal. In particular, of the relatively limited attention that has been paid to the accounting practices in the British voluntary hospitals, none of that work focuses fully on the practice of annual reporting by the hospitals either in terms of its emergence, development or practice and that is where the main contribution of this thesis lies. The next section will examine the methodology that will be adopted in this study.

2.5 A Theoretical Framework

2.5.1 Accounting as a Mechanism of Power

If we consider Leonard's conception of quantitative measures in welfare provision as 'predominantly designed to fit the user into the preferred structures of the ex-

pert, and do so in the name of efficiency and rationality and as a defence against the ever-present fear of their opposites' (Leonard, 1997, p91) it is possible to discern techniques of quantification and classification as technologies and mechanisms of power working on individuals within the population. Yet, to ascribe such a quality of power as being an inherent characteristic of quantitative and accounting technologies would be to miss the point of their location within the organised structures of welfare. Foucault elucidates this point when he says that 'nothing can function as a mechanism of power if it is not deployed according to procedures, instruments, means, and objectives which can be validated in more or less coherent systems of knowledge' (Foucault, 1997, pp. 52-53). Thus, quantitative mechanisms like accounting cannot act in isolation, but must act on behalf of and in support of some systematic body of knowledge. These bodies of knowledge, whether they are medicine, psychiatry, criminology, social work, or any of the other disciplines that combine to form the structures of the modern state are held to create a form of disciplinary society in which the individual is forced to conform to the policing actions of the institutions concerned. Brass (2000, pp. 308-309) summarises the argument neatly:

> "in many activities, one's status as a citizen matters little and confers no political power. In many cases, the individual becomes not a citizen (more or less participant in the political process, with an armoury of rights and protections), but a case - a social worker's case, a psychologist's case, a medical doctor's case, a lawyer's case ... those who exercise such techniques constitute an authority established not by democratic means but by induction. They occupy positions of power that are deemed legitimate because of their knowledge. They exercise that power through the examination by turning the individual from a citizen, who may belong to a broader group of like-minded citizens with potential influence in society, into an "effect and object

> of power" and of knowledge. The purpose of that power and knowledge is to establish "individual difference" in order to treat, confine, or exclude individuals deviating from normal."

Therefore, accounting along with other quantitative techniques is embedded within and implicated in the exercise of subtle mechanisms of power that serve to normalise and control modern populations through the mechanisms and the institutions of welfare organisations. These organisations each have their own body of systematic knowledge which serve to legitimate their actions and existence within society. And so, to fully understand technologies such as accounting in the context of hospitals we must examine them with reference to the bodies of knowledge and practices within which they are located and in relation to the population(s) that are governed by the institutions concerned.

2.5.2 Governmentality

This perspective falls within the remit of what has been termed by Foucault "governmentality"[6] (Foucault, 1991). This modern form of government is held to have emerged when statistical analysis of the eighteenth century demographic expansion showed that 'population has its own regularities, its own rate of deaths and diseases, its cycles of scarcity, etc' and 'by making it possible to quantify the specific phenomena of population' that 'the domain of population involves a range of intrinsic, aggregate effects, phenomena that are irreducible to those of the family'

[6] The term governmentality is a neologism created by Foucault from the phrase governmental rationality

(p99). The end of this government is not some form of malign control but, 'the welfare of the population, the improvement of its condition, the increase of its wealth, longevity, health, etc.' and further, that:

> "the means that the government uses to attain these ends are themselves all in some sense immanent to the population; it is the population itself on which the government will act either directly through large-scale campaigns, or indirectly through techniques that will make possible, without the full awareness of the people, the stimulation of birth rates, the directing of the flow of the population into certain regions or activities, etc." (p100)

And so, a form of government emerged that turned its back on structures of sovereignty and becomes instead a 'political science' which 'turns on the theme of population and hence also on the birth of political economy' (p101).

Notably, Foucault does not consider governmentality to be a departure from his earlier work, but rather, an extension and development of it. The themes of discipline and surveillance that emerged most strongly in *Discipline and Punish* and the *History of Sexuality* (Foucault, 1977, 1979) are not only continued, but are brought forth as: 'never more important or more valorized than at the moment when it became important to manage a population' (1991, p102). And so techniques of surveillance and disciplinary mechanisms become central tenets of a governmental rationality whose object is the management of the population.

That this conception of government has been taken up by a significant number of researchers working in a variety of fields cannot be denied. However, to attempt to express precisely the way in which governmentality has been and is being used within this range of research agendas, would be to risk ignoring significant

differences in the way that it has been adopted and applied by different individuals. This is perhaps because governmentality was never intended by Foucault to be a simple universal concept applicable to all areas of research. Rather, it was held to be a 'zone of research', the study of 'the conduct of conduct' (accurately reflected in the way that it has been taken up), within which different rationales and techniques of government would emerge. The potential diversity is highlighted by Gordon when he points out that 'government as an activity could concern the relation between self and self, private interpersonal relations involving some form of control or guidance, relations within social institutions and communities and, finally, relations concerned with exercise of political sovereignty' (Gordon, 1991, pp2-3). Alternatively, Dean has conceived it as: 'concerned with the means of calculation, both qualitative and quantitative, the type of governmental authority or agency, the forms of knowledge, techniques and other means employed, the entity to be governed and how it is conceived, the end sought and the outcomes and consequences' (Dean, 1999, p11).

Despite the precision that these lengthy definitions impart, they only serve to highlight the immense breadth of territory, sweeping across disciplinary boundaries, that is encompassed by the study of governmentality. It is no surprise, therefore, to view the wide range of work that has emerged 'across disciplines as diverse as politics, sociology, economics, accounting, law, philosophy, the history of ideas, education and the history of the human sciences' (Dean, 1999, p3). Most interesting to this study, of course, is the body of work that has emerged within accounting.

While it is not difficult to include studies such as that by Miller and O'Leary (1987) in the literature on governmentality it deals with the government of population within a closed institution, namely that of the factory. This business perspective, inheres in much of the governmentality work done in accounting, however, some of this work steps clear of the confinement of the factory, or business organisation, and deals with the use of accounting by government in an open social context. The genesis of this work in accounting is found in the paper by Miller and Rose (1990) entitled 'Governing Economic Life' , the methodology for which emerged in their earlier work on the Tavistock Programme (Miller and Rose, 1988).

2.5.3 Governmentality and the State

What distinguishes Miller and Rose's 1990 paper from preceding Foucauldian studies is its examination of macro-level promotion of accounting rationales in the pursuit of specific political ends. For instance, one example which the paper discusses was the attempt in the 1960s and 1970s to promote ideas of investment decision making that were focused around discounted cash flow techniques. With growing support from a wide range of bodies, drawn from both political and labour organisations, there was a growing consensus through the 1960s and '70s that national economic growth was essential, for different reasons, for both capital and labour. As a result, DCF techniques were 'actively promoted through government bodies such as the NEDC [National Economic Development Council] and strongly recommended by the Treasury for the nationalised industries' (p16). The aim of this pro-

gramme was to discourage short-term investment, by discrediting techniques such as payback and promoting DCF techniques which support longer-term projects, thus promoting long-term growth in the national economy. The strength of this mechanism was in the discreet way that it encouraged people and businesses to act congruently towards the common goal without the imposition of any centralised planning measures; thus was resistance subverted. This case highlights one of the central features of governmentality; namely is its rather unusual conception of the state.

Instead of accepting the reduction of political power to the action of a monolithic state, 'the latter construed as a relatively coherent and calculating political subject' (p3), Miller and Rose (1990) argue that:

> 'the notion of government draws attention to the diversity of forces and groups that have, in heterogeneous ways, sought to regulate the lives of individuals and the conditions within particular national territories in pursuit of various goals. Rather than 'the state' giving rise to government, the state becomes a particular form that government has taken' (p3)

It is this definition of the state and its outputs as being the product of a social construction of multiple and diverse groups within society, each with its own concerns and objectives and its own methods for the achievement of those objectives, that was developed in later papers (Rose and Miller, 1992: Miller, 1992: Miller and Rose, 1995a,b). It can also be viewed as a central feature in the work of those other authors who have adopted governmentality as a methodological approach.

Although a number of studies exist which have broadly adopted this approach (see for example Hopwood and Miller 1984), several recent studies have begun to examine the use of accounting as a technique of government, outside the arena of the business organisation. Firstly, in fascinating work (Neu, 1999, 2000: Neu and Therrien, 2003: Neu and Graham, 2006a,b) Dean Neu describes how 'accounting discourses and techniques played a significant role in the subjectification and control of indigenous peoples' (2000, p164). Highlighting the intersection of the 'softwares' of accounting with the military 'hardwares' of empire, Neu argues that as a result of 'cost-cutting and reformist sentiments', native peoples in Canada were identified by the British administrative bureaucracy as a possible centre for the reduction of military expenditure. He goes on to suggest that it was really at the level of colonial administration that the identification of the indigenous peoples as a site of government took place and that it was at this level that accounting and others techniques were utilised in the attempt to turn indigenous peoples into a governable population. Secondly, in a fashion not dissimilar to that described by Miller and Rose, Preston et al (1997) show how, as a result of powerful lobbies from the elderly and from the wider public in support of the elderly, the US government introduced diagnosis-related groups (DRGs) and prospective payment systems (PPSs) in order to govern the actions of Medicare providers in the 1980s. In this way, they managed to initiate 'action at a distance' and 'technologies of government suppressed the difficulties inherent in rationing health care to the elderly' (Preston et al., 1997, p161). However, despite the successful and innovative work that has arisen from

it the approach advocated by Miller and Rose did not pass unchallenged. The disaggregated conception of the functioning of government has not appealed to some, typically Marxist, critics of the governmentality approach.

2.5.4 The State or not the State

Curtis (1995) in particular, took exception to Miller and Rose's 1992 paper, claiming that they tried to create a new understanding of the state and government while simultaneously failing to define either concept. He further accuses them of adopting a position which denies human agency and, that their claim that rationales of government will lead to a multiplicity of centres of calculation and intervention has failed to be borne out by empirical work which tends to focus on legislative intervention (Curtis, 1995). Miller and Rose's response focuses on what they perceive as Curtis' dogmatic view of a monolithic state, directing society from the top. They point out the 'weakness of conventional accounts of state and politics' due to their 'focus upon the internal organisation of the political apparatus and the legitimating discourses of philosophy and jurisprudence' and the way in which they marginalize fields of expertise such as accountancy. Then, they disarm Curtis' claims by arguing that 'analytics of government and governmentality do not offer a new theory of the state, politics or modernity, nor even a new 'theory of power'. Rather, they address the operation of power, from a particular perspective ... this neither extends government to the whole of 'human interaction' as Curtis suggests nor seeks to draw everything back to a single locus or institution but multiplies the

sites of emergence of technologies of role and the forms they assume' (Miller and Rose, 1995a, p591). Nevertheless, Curtis' point about the tendency of researchers to focus upon issues which involve the legislature has, at least with respect to accounting research, some force.

Jones' study of accounting formations in local government between 1800 and 1995 does go some way to demonstrate the capacity of accounting as a mechanism of government at a sub-national level. However, it does tend to highlight that accounting researchers have typically sought to analyse accounting as a technique of government in some 'official' capacity, whether that be either at the level of national government, or in Jones' case at local government. Nothing has been written about the role of accounting in nonofficial governmental formations; i.e. formations that have not been sanctioned by and are not part of the structures of the state. It is in this particular area that the current study hopes to break ground, by analysing the discursive formations which promoted the emergence of accounting techniques that were used to 'govern' the populations surrounding the large and influential institutions that were the voluntary hospitals. Further, this study will concern itself with the discursive formations that were instrumental in drawing the voluntary hospitals together into the beginnings of the hospital system that we know today and will provide an analysis of the accounting practices that emerged from those discourses and of the role that they played in the creation of the British hospital system.

2.6 Sources

In the attempt to analyse accounting discourses at both the micro and macro level within the British hospital system, this study will use a variety of archival sources. Firstly, in the examination of discourses at the individual hospital level material from the archive of the Edinburgh Royal Infirmary (ERI) will form a major part of the next chapter. The ERI has been chosen, because it was the first voluntary hospital in Scotland, amongst the very first in the UK and because it was immensely influential, both in terms of the development of scientific medicine and in terms of its position in the community in Edinburgh and in Scotland. As the study broadens out to encompass a more macro analysis of the process by which the voluntary hospitals began to coalesce into a system the sources will shift into the medical journals of the day, such as *The Lancet*, the *British Medical Journal* (BMJ) and also *The Hospital*, a journal designed for hospital administrators. These journals provided the forum for debate, for all things medical and also, for all things to do with the hospitals. As such, they provide remarkable insights into the dominant discourses of the day. Additional materials will come from the *Transactions of the National Association for the Promotion of Social Science*, an organisation set up for the purpose of reforming many social institutions, including the hospitals. Supplemented by additional secondary sources, these materials provide a unique insight into the primary discourses of hospital development throughout the 18th and 19th centuries.

3. ACCOUNTABILITY AND THE ANNUAL REPORTS OF THE ROYAL INFIRMARY OF EDINBURGH 1818-1852

> "From admiration to this parent God, Some gen'rous souls, with pious energy Presum's to imitate the SOVEREIGN GOOD, By heaping blessings on their fellow creatures. T'was then the reign of charity began; And Hospitals were rear'd to heal the sick, And raise the poor man who had none to help him." (Wilde, 1810, p24).

3.1 Introduction

It is probably normal for us to think of the organizational annual report as a mechanism or technology of accountability, the primary focus of which is upon the outputs and performances of the organization and the actors within it. However, in nineteenth-century Britain, it was normal for at least one type of organization[1] to publish annual reports of unusual size (sometimes running to hundreds of pages), that tended to focus their attention on subjects external to the organization. These were the old 'voluntary' hospitals; institutions that were supported entirely by charitable funding and reliant on the generous impulses of those wealthy enough to provide subscriptions and contributions. It was these charitably-minded individuals that primarily were subjected to the scrutiny of the hospitals' annual reports, rather

[1] Other forms of charity also published annual reports, but the reports of the hospitals were to become unusual in their scale and scope.

than the internal activities and management of the institutions concerned. This counter-intuitive structure is worthy of investigation if only as an example of an accountability that seems to operate in reverse, extending beyond the boundaries of the organization into the social spaces that surround it to examine its financiers. But it also offers the opportunity to examine the structures that are formed by an accounting mechanism as it penetrates and permeates that social space. To this end, this chapter will study the annual reports of nineteenth-century hospitals and, in particular those of the Royal Infirmary of Edinburgh, in order to explore the emergence and function of this instance of accounting practice.

The focus of this chapter is not only historical curiosity over the origins of this practice, but also an examination of the annual report as a mechanism of accountability and of the structures that, where conditions allow, are promoted by the adoption of such a mechanism. To approach this task a framework is derived from the findings of Roberts and Scapens (1990) in their study of the accounting as a disciplinary practice deployed with the intent of creating structures of accountability. While this work was itself based upon the writings of Foucault (1979) it is the particular construction of accountability structures that Roberts and Scapens identified within the context of a divisionalized company that will be used here to reflect upon whether parallels exist between the nineteenth-century structures of accountability working in an open social space and twentieth-century structures displayed within the confines of a modern organization. The existence, or otherwise, of such parallels may indicate whether pre-existing organizational

structure is required for such accountability to occur, or whether the application of a mechanism of accountability such as the annual report is in itself capable of creating such structure and defining its own form of organization.

The work done by Roberts and Scapens had a particular theoretical stance. Rejecting views of accounting as either a set of neutral, objective techniques, or as an element in a system of domination of labour by capital, they instead assumed it as a disciplinary technology capable of creating visibilities in fields of activity and exercising a relational power; a power not possessed by any particular individual, or adopted as a coercive force, but rather a form inherent in all social relations, (Roberts and Scapens, 1990, pp 107-108). The use of this Foucauldian conception of power was not then novel, having previously been applied in a number of studies (Hoskin and Macve, 1986: Loft, 1986: Miller and O'Leary, 1987), but their focus was particularly directed towards individual accountability and the analysis revealed a particular structuring of the nature and relations of accountability within the organization under study.

In particular, the analysis firstly sought and identified a hierarchical accountability that struck through tiers of management by means of the accounting information system and was exercised through analysis of variances from budgeted standards. Managers were forced to come to terms with the technical aspects of the accounting as they were required to explain any variances that had occurred. The periodic reports created a field of visibility in which the manager was able to

locate his own performance and was encouraged to avoid deviance. Yet, the fields of visibility were not unbroken, the reports left blank spaces, areas of operations about which no data was gathered, which managers could use to 'shield themselves from the attention of their superiors' (Roberts and Scapens, 1990, p. 116). Thus, managers had an interest in creating and maintaining areas of obscurity about their operations. The second important aspect of the analysis was the observation that functional divisions within the organization served not only as a convenience of the accounts, but served to separate or divide people setting them against each other. Typically, the managers of one function would blame any adverse results on the actions of other functions. At this point, the relevance of these observations to an analysis of the annual reports of a nineteenth century hospital may be unclear, however, the significance of these hierarchical structures of accountability and the separation of the entity into segregated units are structures based on Foucault's wider conception of the nature of power and should perhaps be discernible in other settings.

Roberts and Scapens identified the company's main board as the apex of the hierarchy of accountability, yet also spoke of the pressure created by the financial markets and institutional investors. Nevertheless, their analysis did not include the annual report in the system of accountability, staying instead within the boundaries of the organization. But clearly, it is the annual report that is the summit of the accounting information system providing that last link in the chain of accountability. This chapter will examine the location of the annual reports of voluntary hospitals,

in particular the reports of the Royal Infirmary of Edinburgh, as a mechanism of accountability that should have offered to the contributors a way to ensure that their money was being well managed, but rather appears to have been deployed more effectively as a means of scrutiny of the efforts of the contributors themselves.

The next section of the chapter will outline the context of the formation of the voluntary hospital movement, discussing the motivations of the contributors, showing that involvement in such institutions offered increased status and social and business contacts. Many ambitious individuals wanted to be perceived as benevolent and were prepared to donate to hospitals, in order to see their names appearing in the widely published annual reports. These documents will be shown to be relatively ineffectual as a means of internal penetration of the workings of the hospitals and will argue that they offered a means by which hospital managers could reflect on the activities of contributors. Subsequent sections will explore how the increased financial pressures on hospitals arising from inflationary periods and demographic and social changes created the need to find methods of increasing funding. Then it will be shown how the managers of the Royal Infirmary of Edinburgh were able to achieve this objective by collecting and analyzing the data that they had on contributors and, by structuring the data into geographical and social groupings they were able to create fields of visibility that displayed the extent of donating activities. This allowed them to question the benevolence of certain sections of the populace through the medium of the annual report and enabled them through pressure applied by collectors to achieve significant gains in the performance of

contributors.

3.2 The Voluntary Hospitals

The eighteenth century in Britain saw the emergence of an important new form of medical care, aimed specifically at the poor. The beginning of the century had seen a country almost entirely deprived of hospital provision. The old monastic orders, whose focus was on the provision of care for the spiritual and moral needs of the populace as well as their physical ailments, had been almost completely destroyed in the reformations under Henry VIII and Edward VI. The major significant survivors of this were St Thomas' and St Bartholomew's Hospitals and the Bethlem madhouse (Bedlam) in London, which were re-endowed with new charters (Copeman, 1964). Elsewhere there is little evidence of the survival, or re-establishment of, monastic hospitals (Porter, 1993, p. 15). The gap in provision that this created cannot be understood in terms of modern medical systems as the numbers catered for by the monasteries must only have been a fraction of the entire sick population. Nevertheless, the lack of hospital care became significant and by the early eighteenth century responses were forming.

In the first half of the eighteenth century, particularly in London, a few new hospitals began to appear; funded either by an endowment provided by an individual, or more likely, by the organization of a group of charitably minded individuals providing regular subscriptions for the creation and maintenance of an institution

to provide relief of the 'deserving sick poor'[2]. These 'voluntary' hospitals had certain common principles: the provision of free medical treatment to the poor; funding through the donation of free-will subscriptions towards the construction of hospital buildings and their annual upkeep and maintenance; administration by voluntary management, usually drawn from the ranks of subscribers and supplemented by other esteemed individuals and, finally, the supply, free of charge, of medical services by honorary physicians and surgeons[3]. Whilst the endowment of new hospitals by wealthy individuals remained sporadic, by the second half of the century the trickle of hospitals founded by voluntary subscription had become a flood with hospitals being created in most major cities in the British Isles by the middle of the nineteenth century.

3.2.1 An Outlet for Charity

The reasons for the emergence and rapid growth of what has been termed the voluntary hospital movement are complex, but it has been argued that prominent among them was a growing need for an outlet for 'the most lasting, valuable and exquisite pleasure' [of Charity] (from the Gentleman's Magazine 1732 and quoted

[2] A distinction was drawn between these two types of hospital: those founded by a single donation, such as Guy's in London, the Radcliffe in Oxford and Addenbrooke's at Cambridge, were typically provided with estates as sources of income and these institutions along with St Thomas' and St Bartholomew's in London were referred to as the 'endowed hospitals'. Alternatively, those hospitals founded and supported only by voluntary subscriptions and contributions were referred to as the 'voluntary hospitals'

[3] It should be noted that despite the existence of a hierarchical tri-partite structure within the medical profession consisting of the Physicians, Surgeons and Apothecaries, the medical corporations had no statutory authority at this time and the majority of medical practitioners were neither members of these chartered medical corporations, nor recipients of formal medical training.

in Owen, 1965), sponsored by the increasingly strident urgings of religious leaders on behalf of the poor. William Warburton speaking in 1742 pointed out that it is:

> "to the poor ... that we are immediately, and almost solely, indebted for every advantage of ease and pleasure, which improved and refined society affords ... it is being by their incessant toil and labour that these elegancies are procured for us ... [and their] maladies ... [are] chiefly contracted in our service, in an incessant application of all their faculties to the supplial of our imaginary, and, therefore, endless wants and conveniences" (Porter and Porter, 1988, p181).

Presented with this type of argument and confronted with daily exposure to the sufferings of the poor[4], 'the rich company laundered their wealth with philanthropy; they underwent a temporary catharsis which purged the soul while leaving the lifestyle essentially intact' (Borsay, 1991a, p228). This they were told, would not only ease their conscience, but also improve their prospects at the day of judgment as, 'in the classical mode of Enlightenment utilitarian piety, it was also suggested that giving today was in fact a form of investment for the hereafter' (Porter, 1989, p162). 'These poor people cannot recompense you;', preached Bishop Maddox in 1743, 'but you will be recompensed at the resurrection of the just' (Maddox, 1743, p24). Olive, in 1759, expounded that 'the thankful poor ... [Will] continually send up their prayers for you to the throne of grace; and He who sitteth thereon, and heareth the supplications of the poor and needy shall pour down upon your heads the abundance of his blessings' (Borsay, 1991a, p226), while Bishop Gibson claimed that, 'whatever is laid out in Charity, God accounts an offering and a loan to himself: and accordingly he engaged to repay it' (quoted in Rogers, 1949, p7).

[4] Such confrontation was inescapable for those living in the cramped and unhygienic conditions of 18th and 19th-century towns and cities.

Thus philanthropy could be perceived less as an act of altruism and more as a form of, 'ritual giving, whereby the rich paid an accepted 'debt to society" (Checkland, 1980, p4) while simultaneously improving the immortal soul.

Philosophers of the emergent Scottish enlightenment wrote of the opportunities that philanthropic acts provided benefactors to influence the esteem in which they were held. David Hume, prevented from ever taking up an academic position because of his atheistic views, nevertheless observed that, generosity and beneficence 'raise the possessors of them above the rank of human nature, and make them approach in some measure to the divine', thus separating the good from the 'merely great and wealthy'. 'Exalted capacity, undaunted courage, prosperous success;' he added, 'may only expose a hero or politician to the envy and ill-will of the public: but as soon as the praises are added of humane and beneficent; ... envy itself is silent, or joins the general voice of approbation and applause' (Hume, 1997, p149). Through acts of charity, therefore, those with sufficient resources could effectively buy themselves public acclaim as generous, humane and benevolent individuals, worthy of admiration as well as revealing their wealth relative to others in the social order.

The existence of such ulterior motives for charitable acts was unlikely to detract from them, even if they were detected. Francis Hutcheson observed; 'that such a man has also in view private advantage, along with public good, as the effect of his action *does no way diminish the benevolence of the action*' (Hutcheson, 1997, p132,

emphasis added). The point was inescapable, that the motive for an act of charity did not in any way devalue the benefits that arose from it; the main criteria for the evaluation of the action lay in a proto-utilitarian assessment of the consequences for the needy, not in any advantage, pecuniary or otherwise, that may have been realized by the benefactor. The giver could give, confident in the knowledge that it would have a positive effect on his standing in the community.

3.2.2 The Ubiquity of Illness

It may be overly cynical to suggest that acts of charity were carried out only for material or metaphysical gain. Borsay is, most likely, correct when she states that 'gifts ... repaid the donor with the warm glow of giving' (Borsay, 1991a, p217). That medical care, therefore, should emerge as a one of the most significant outlets for philanthropy is unsurprising. The experience of ill-health as a unifying force, capable of being understood across class boundaries, has been explored in pioneering work on the lives of patients by Roy and Dorothy Porter (1988, 1989), as they surveyed the ubiquitous themes of sickness and injury prevalent throughout society. For example: 'Everybody is ill', exclaimed Keats to his brother in 1820. 'This was neither a metaphysical paradox nor a piece of poetic license,' observed the Porters, 'but merely an update on his friends and family" (Porter and Porter, 1988, p6).

Keats' problem of the constant exposure to illness and disease, which ultimately led to his own untimely death from consumption, was universal. Disease and infection were not confined to the poorer classes. For instance, the Queen of Portugal

was reported in 1699 to have died from an infection acquired after an ear piercing. Death and illness had no respect for class. But, death was not the most common outcome: 'For every disease that killed, dozens merely caused pain, disrupted lives or disabled sufferers, temporarily or permanently, from work, physical mobility, pleasure or peace of mind' (Porter and Porter, 1989, p6). The prevalence of such disability led to calls for the provision of medical care to those poor people who could not afford it. Bishop Duncumb preached in 1797 to the Cathedral Church of Hereford that, 'to substitute hope for despair, to alleviate the poignancy of unexpected distress - to soothe affliction - and to administer comfort on the bed of despondency and sickness - are actions which every generous mind must feel pleasure in performing', (quoted in Woodward, 1974, p19). The sympathetic desire of the wealthy to exercise philanthropy by healing the poor was given additional impetus and legitimacy by the doctrines of mercantile economics.

3.2.3 Mercantile Economics and the Health of the Nation

In a lecture he delivered in 1676, the early political economist, William Petty, hypothesized the potential economic gain that could be realized by the nation through the provision of improved medical care:

> "suppose that in the King's dominions there be 9 millions of people, of which 360,000 dye every year, and from whom 440,000 are borne. And suppose that by the advancement of the art of medicine a quarter part fewer dye. Then the King will gain and save 200,000 subjects per annum, which valued at £20 per head, the lowest price of slaves, will make 4 million per annum benefit to the commonwealth." (Quoted in Woodward, 1974, p7)

Almost forty years later in 1714, John Bellers called for a major state hospital construction programme to realize this potential after calculating, by different process, that the kingdom lost about a hundred thousand inhabitants per year to curable diseases and that 'Every Able Industrious Labourer, that is Capably to have children, who so Untimely Dies, may be accounted Two Hundred Pounds Loss to the Kingdom' (Bellers, 1714, pp1-3). Bellers' calls fell on deaf ears. The 18th-century state was neither willing nor able to provide the enormous investment that would be required by such a programme. However, the argument was not lost on the wider public and isolated groups of individuals, who perceived that provision of a hospital was 'an attractive means of philanthropy ... less subject to abuse than non-medical charities and [which] could not be regarded as encouraging laziness' (Pickstone and Butler, 1984, p229), began efforts to establish hospitals in numerous locations in Britain over the next century.

Central to these efforts was the theme that the provision of medical care through the auspices of a hospital would restore the productive capacity of the sick poor and was the most economical and efficient method available (Barry and Jones, 1991, p6). Reflecting Bellers' opinion that 'it is as much the duty of the poor to Labour when they are able as it is for the rich to help them when they are sick' (Bellers, 1714, p6), the proposal for the Bath infirmary highlighted those unfortunates who 'by the loss of their limbs, are become a burden to themselves and their neighbours' and of the ability of an Infirmary to render the sick poor 'comfortable to themselves, and profitable to the public'. It further spoke of delivering the poor and distressed

'from impotence to strength, from beggary and want, to a capacity of getting an honest livelihood, and comfortable subsistence' (Borsay, 1991a, p215). An early (unsuccessful) attempt to establish an Infirmary in Edinburgh pleaded that:

> "Humanity and Compassion naturally prompt us to relieve our Fellow Creatures when in such deplorable Circumstances as many are reduced to, Naked, Starving, and in the outmost Distress from Pain and Trouble of Body and Anguish of Soul ; That as the Relief of these is a Duty, so it is no less Advantage to a Nation, for as many as are recovered in an *Infirmary* are so many working Hands gained to the Country" (Extract from a pamphlet published in 1721 in support of the foundation of an Infirmary in Edinburgh and quoted in the minutes of the Committee of Management of that organization in 1730.)

At Winchester, 16 arguments were listed as reasons for the establishment of a hospital (Winchester County Hospital, 1737). These ranged from the promotion of economic gain by 'increasing the number of People; as well as of saving a multitude of Hands, who are often lost for want of timely assistance'[5], through to, 'reduc[ing] the number of vagrants by depriving them of one of the most plausible reasons for begging from door-to-door, under the specious pretence of sick relations of friends for whom they are concerned'. By the provision of care for the sick relation, argued the sponsors, 'they who are idle and able to work, will be obliged to have recourse to employment, and become serviceable members of the community'. The Winchester arguments also highlighted the potential for an infirmary to provide other benefits, as it would encourage 'Parishes (when they are relieved of the great burden of supporting the Sick) to provide better for the maintenance of Orphans and Aged persons' (p151). Thus, the voluntary hospital was presented as a panacea for the

[5] The authors added that, 'it deserves to be remembered, that a third part of what every labouring Man earns, is so much clear gains to the public'

sickness of the poor, and an aid to the growth of the economy; providing succour in time of need, in order to speedily return individuals to productive efficiency, while at the same time relieving the burden of expense from the Poor Law.

Health care, it was also claimed, could be provided most efficiently in the setting of a hospital. The economies of scale available in such an institution were such that 'the expence of relieving a great number of sick persons in an Hospital, bears no proportion to that of assisting them at their separate homes' (Winchester County Hospital, 1737, p150). Also, promoters were not slow to point out that services could be provided in hospital that were simply not available elsewhere: 'these Helps, also, tho' not obtainable in any other method at any Price, are, as Experience evinces, here procured at the most moderate Expense' (An Address to the Nobility, Gentry, Clergy and others, in behalf of a Public Infirmary erected at Liverpool, 1 March 1748-9, quoted in Woodward, 1974, p14). Such assurances were essential, as sponsors knew that for any hospital scheme to work, funds would have to be solicited on a regular basis from the more moderately wealthy (but rapidly increasing in numbers) middle classes. These people, who typically placed their charitable donations with great care, were enticed into infirmary schemes by the prospect of social mobility through increased status.

3.2.4 Philanthropy and Status in the Annual Report

The opportunity to increase social status by mixing with the aristocracy was an important factor for many middle-class subscribers to hospitals. The difficulties

experienced by John Harrison the chief promoter of the London hospital were overcome when, 'At a time when only a 100 Guineas had been guaranteed and the viability of the project was in doubt, Harrison announced to a meeting of interested people that the Duke of Richmond had become a subscriber, thus setting the seal on the worth of the institution' (Woodward, 1974, p18). At Edinburgh, Steedman recounts that 'the fund increased slowly ; but after the [Royal] charter was granted[6], the public was convinced of the benefit that might be reaped from an Infirmary of greater extent' (Steedman, 1778, p8).

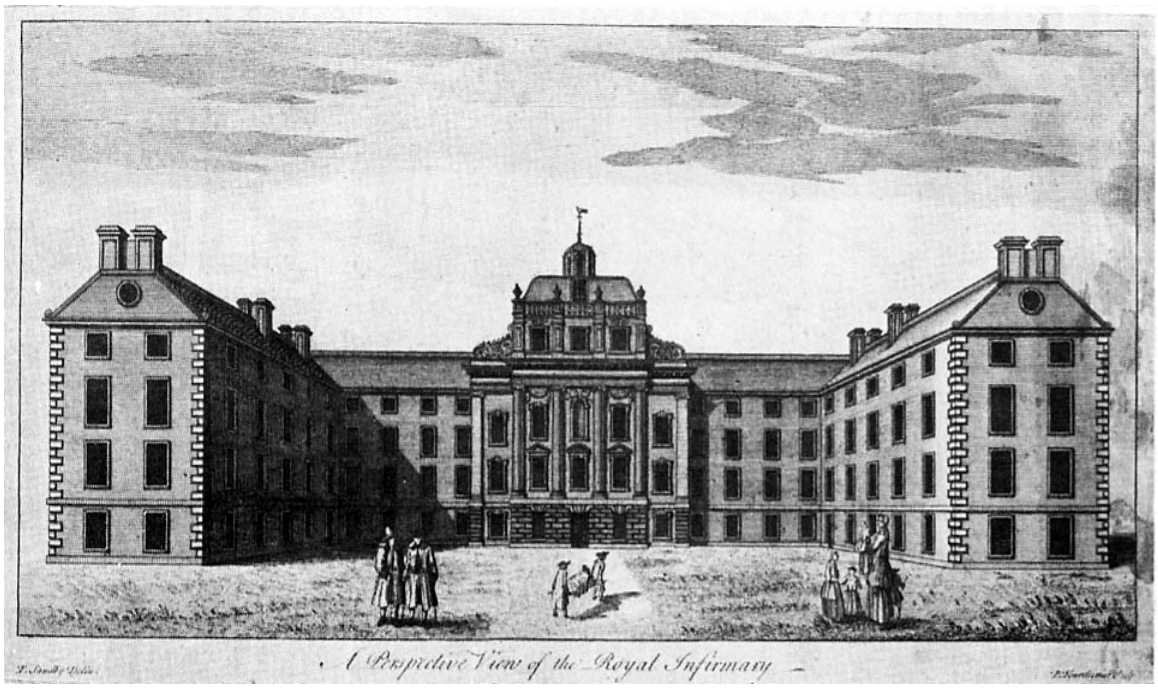


Fig. 3.1: **The old Royal Infirmary of Edinburgh: built by public subscription**

Subscription systems, 'allowed the nouveaux riches to be coupled publicly with their social superiors, at a time when the middling ranks of society were increasing in wealth and social aspirations' (Borsay, 1991a, p218). Public and fundraising

[6] The charter was granted by George II in 1736

ceremonies associated with hospitals allowed middle-class subscribers to become visible as benefactors, particularly as, 'The anniversary sermon and annual meeting of the voluntary hospital had become a recognized social occasion when the subscriber learned of all that his generosity had meant to the poor and found himself in a pew commensurate with his largesse' (McMenemey, 1964, p62). In some places, such as Birmingham, grander events took place, as the hospital 'was mainly supported by triennial musical festivals, at which such works as Mendelssohn's "Elijah" conducted by the composer himself, and numerous other compositions of high merit written expressly for the Birmingham music meetings, were performed' (Hall and Harral, 1967, p1). Participation in these social occasions allowed the middle-class subscriber to be seen cheek-by-jowl with the upper ranks of society thus acquiring, 'prestige in the eyes of his neighbours, his employees and his tradesmen' (McMenemey, 1964, p57).

The ability to make visible a certain social superiority, not just over their neighbours, but especially from the lower ranks of society, was important to middle-class subscribers. Roy Porter has argued that the voluntary hospitals were instruments designed to act upon the poor in a way described by Braudel's concept of the gift relation - that he who gives, dominates (Porter, 1989). Within the confines of the hospital, the poor were given instruction as to the acceptance of their proper place in society:

> "They are provided here with the use of the best Books, and have daily opportunities of being instructed by Those, whose Duty it is to attend upon this very thing ... For We can never hope to secure their Affections, soften their Passions, reform their

> Manners, and possess them with a sense of their Duty to God and Their Superiors so effectually as by this feeling way to Instruction" (Winchester County Hospital, 1737, p152).

Inmates were often required to parade in front of visiting dignitaries, demonstrating their suppliancy in a 'ritual theatre of patrician power' (Porter, 1982). Also, by providing access to medical treatment through the voluntary hospital, the rich elites, aristocrats and middling sorts alike, were able to demonstrate their beneficence and high moral worth, while simultaneously eliciting supplication and gratitude from those lower orders of society that were objects of the charity. By requiring the poor to entreat for a subscriber's letter, the most significant tangible benefit received by subscribers to a hospital (Hart, 1980), the subscribers were established as judges of the worthiness of those who sought hospital treatment. Those granted the gift of the letter, were expected to be filled with gratitude and expressions of that sentiment were enforced by hospital rules. Dischargees from the London hospital were required to:

> "attend devoutly in the Chapel of the Hospital on Monday next at 10 o'clock in the forenoon, and also in your Parish Church or other usual place of worship on the Sunday after you are discharged, publickly to return your thanks to Almighty God for His great goodness to you. You will have a paper given to you to be conveyed to the Minister for that purpose. That you appear to return thanks before the Committee on Tuesday morning next at 11 o'clock, and that, if admitted by a recommendation, you by no means omit to show your gratitude, and give notice of the opportunity for some other distressed person to be relieved, by delivering the letter of thanks, which will be given to you, to the governor who recommended you." (Extract from a printed notice, given to patients being discharged from the London Hospital. Reproduced in Morris, 1910, pp110-11.)

Those who failed to comply with this procedure were warned that they would show themselves, 'ungrateful both to God and Man', and, 'wholly unworthy of the

blessings and benefits', that they had received. They were then threatened that they would be, 'deservedly precluded from any future relief at this hospital' (Morris, 1910, p111). Thus enforced, the poor recipients of treatment were compelled, meekly, to express gratitude for the favour shown to them by their good patron; thereby defining and reinforcing the social distance between them.

Although such deference was held due to all who supported the voluntary institutions, those who wished to maximize the possibilities of social mobility and economic opportunity would seek particularly to become involved in the management of the hospital, as it 'favoured the creation of networks of interest allowing the establishment of contacts, business links and influence over work and career opportunities' (Cavallo, 1991, p52). Investment of time in the management of an Infirmary, was highly effective for middle-class individuals, because the scope for extended personal contact with social superiors was greatly increased, providing maximum access to this 'most powerful medium for the transfer of social kudos' (Borsay, 1999, p285). Afforded almost complete independence in the management of the hospital, middle-class managers 'acquired confidence from their infrequent encounters with the aristocracy and gentry, and identity from their frequent encounters with each other' (Borsay, 1999, p286). Therefore, for those involved in the management of voluntary hospitals there was a genuine desire to promote the interests of the institution; as the hospital expanded its activities and grew great and prominent, so did those who were responsible for managing its rise, through their increased identification as the moral leaders of society (Granshaw, 1990, 1992).

GRAND ANNUAL FANCY BALL
FOR THE BENEFIT OF
THE ROYAL INFIRMARY,
FRIDAY, 3D MARCH,
George Street Assembly Room.

PATRONESSES.

Her Grace the Duchess of Buccleuch.
The Most Noble the Marchioness of Lothian.
The Right Hon. Lady Mary Ross.
The Right Hon. the Countess of Morton.
The Right Hon. The Countess of Wemyss and March.
The Right Hon. The Countess of Dalhousie.
The Right Hon. the Countess of Leven and Melville.
The Right Hon. The Countess of Kintore.
The Right Hon. The Countess of Rosebery.
The Right Hon. the Countess of Glasgow.
The Right Hon. Lady Susan Ramsay.
The Right Hon. Lady Harriet Stuart Forbes.
The Right Hon. Lady John Scott.
The Right Hon. Viscountess Melville.
The Right Hon. Lady Charlotte Murray Macgregor.
The Right Hon. Lady Charlotte Fletcher.
The Right Hon. Lady Louisa Forbes.
The Right Hon. Lady Mary Dundas.
The Right Hon. Lady Robert Kerr.
The Right Hon. Lady Douglas Gordon Hallyburton.
The Right Hon. Lady Belhaven and Stenton.
The Right Hon. Lady Abercromby.
The Hon. Mrs Norton.
The Hon. Lady Menzies.
The Hon. Mrs Dundas.
Lady Campbell.
Lady Hope.
Lady Ramsay.
Lady Clerk.
Lady Stuart.
Lady Dick Lauder.
Lady Riddell.
Lady Arbuthnot.
Lady Gibson-Craig.
Lady Jardine.

Fig. 3.2: **Part of an advertisement for the 'Grand Annual Fancy Ball' for the benefit of the Royal Infirmary of Edinburgh showing the top of the list of the great and good who are expected to attend, *The Scotsman* January 28th 1837.**

Thus, the success of the voluntary hospitals depended on the desire of the philanthroper to be identified as such. Defining themselves by the discourses of charity, benevolence and rational economic action for the improvement of society, the supporters and managers of the voluntary hospitals, were able to construct themselves as both morally and intellectually superior to many of their fellow citizens, and as such, worthy of respect and gratitude. By gaining access to those in the upper

echelons, and subservience from those in the lower, the benevolent were able to utilize this construction to advance their interests, along with their standing in society. Hospital contributors, therefore, were seldom shy about their involvement in a hospital and communications from hospitals to the public typically included effusive discussion about the worthiness of their supporters.

The primary mechanism for the publicizing of contributors efforts were the hospitals' annual reports. These documents were invariably printed in large numbers and distributed widely. In the mid-nineteenth century, for instance, the Edinburgh Royal Infirmary was printing 10,000 copies of its report annually and distributing them in a city of around 27,000 households, only a small percentage of which would have been wealthy enough to make charitable donations. Reports were also sent out to all parishes from which donations were, or might potentially be, received. Thus, through the reports and the attendant newspaper coverage the activities of the hospitals and their benefactors were extensively publicized. Middle class contributors typically found their names in a list alongside those of the great and the good, thus further enhancing their status. Those donating to the Royal Infirmary of Edinburgh, for example, would find their names in a list alongside those of the Duke and Duchess of Buccleuch. This medium provided the visibility that the contributors sought, declaring openly to all social ranks their beneficent involvement in a great philanthropic institution, alongside those other worthy supporters of the improvement of society. At the same time the annual report appeared to offer the supporters of the hospital the opportunity to examine the conduct of its manage-

ment; crucially important as no one wished to be involved in an organization that was deemed wasteful, or inefficient.

3.3 The Annual Report as an Instrument of Accountability

For the hospital managers, the primary objective of the annual report was the maintenance of an image of scrupulous honesty, integrity and efficiency, in the running of the affairs of the hospital and, attractive as the social and economic benefits of involvement were, they had to work hard to maintain this. Any hint of impropriety in management was liable to lead to scandal and potential disaster, for the institution and its managers alike, as the public opprobrium heaped upon the management, would be matched by a drying up of charitable support, at least until the management had been replaced and public confidence restored. However, incidents did take place. Most seriously, a treasurer would occasionally abscond with the funds of a hospital, but, such incidents were rare and reflected attention less on general management competence, than on the personality flaws of the reviled absconder. More likely, was criticism of the day-to-day running of the establishment. Managers frequently found themselves the recipients of queries about their procurement policies, and complaints could occasionally reach the extent of open revolt. This was the case in 1733 when St George's Hospital in London, was founded by a splinter group from the Westminster Infirmary after a dispute over the 'quality and prices of the drugs and certain other alleged abuses' (McMenemey, 1964, p48), with the attendant consequences for the reputation of all concerned at

the Westminster. Hospital managers were extremely careful, therefore, to at all times present an image of propitious and efficient management.

This presentation manifested most powerfully in the form of the annual report a standard practice in hospital management, usually issued from the year of foundation. Bath Infirmary's reports date from 1739 (Borsay, 1991a, p208), Salop's from 1746 (Howie, 1963, p127), and Edinburgh Royal Infirmary (ERI) has reports dating back to its year of foundation in 1729 (YRA 1729). Through this medium, the managers constantly reassured the contributors (who were always interested in how their money was being spent), that the hospital was run as economically as was possible, and backed this up with quantitative information, usually abstracted from the accounts. The reports of the ERI typically contained: an abstract of the audited accounts; a statement of the net capital stock of the hospital (usually arising from the investment of larger legacies and donations); a statement of the number of patients treated during the year; a report by the managers, discussing the content of these statements and commenting on any exceptional circumstances that may have arisen during the year; and also, a list of the subscribers and contributors to the institution. This information formed the basis of the presentation that the managers made, annually, to what was typically referred to as the 'Court of Contributors'; in effect an AGM. After submission, the annual report was usually published and distributed to subscribers, churches and other potential sources of finance, as well as to any other interested parties that may request a copy.

3.3.1 Accountability or Self Promotion?

The annual reports were the primary interface between the hospitals, the communities and wider country in which they operated. Publication was deemed to provide a strong guarantee of the accuracy of the accounts, as the heads of expenditure could be analyzed by those who had provided the goods, as well as allowing their competitors to comment on the reasonableness of pricing. In addition they allowed the subscribers to consider whether the amount spent on, say, wines and spirits was prudent for the number of patients concerned[7]. Equally, contributors had it drawn to their attention, by enthusiastic individuals, that the expenditure on such and such was higher, at their institution, than elsewhere. Dr Philip Doddridge, for example, co-founder of the Northampton Infirmary, was noted for 'the assiduous way he studied the yearly reports from Winchester, Bath, Exeter, York, Bristol, London and Westminster' in order to make such observations (McMenemey, 1964, p53). Yet, despite the ability that the reports gave for critique of management, the effectiveness of that critique was severely diluted by the ability of managers to shift expenditure around. No two hospitals deliberately adopted the same accounting system and the result was that more often than not managers were able to disguise or explain away apparent problems. Also, the interface that the annual reports provided with those who provided funding for the hospitals, allowed the management

[7] Consumption of wines and spirits in the eighteenth and nineteenth century hospitals was typically a major item of expenditure, as these items were regarded as powerful stimulants and staff also were allocated alcoholic beverages as part of their wages. (A typical daily allocation for a nurse at the Edinburgh Royal Infirmary was two quarts of beer a day, plus half-a-bottle of wine.) As a result, it was not unusual for a hospital's drinks bill to reach massive proportions, leading to acid comments, from the Committee of Contributors, about the 'overuse of stimulants'.

Tab. 3.1: Table of Contents: RIE Annual Report 1851-1852

REPORTS

REGARDING THE AFFAIRS OF THE

ROYAL INFIRMARY OF EDINBURGH,

From 1st OCTOBER 1851 to 1st OCTOBER 1852.

CONTENTS

Source: ***Annual Report of the RIE, 1851-52***

a powerful medium for the communication of messages to the contributors.

Annual reports were well used in this regard; subscribers wanted to see success and through the medium of the reports the managers were able to argue that they had achieved it. By the provision of an 'Abstract of Patients', (see Table 1), the managers demonstrated the large numbers of patients that had been treated and the relatively small number that had died[8]. Individual cases worthy of note were often highlighted and at times the claims of rival hospitals progressed beyond the impressive towards the somewhat fanciful. For instance, 'the governors of Winchester Infirmary boasted of having cured a paralytic who had lost the use of his leg for several years, also of the recovery of a patient who had been totally blind in one eye, while at Exeter there was the story of the miraculous recovery of two men so far gone as to be admitted in open coffins' (McMenemey, 1964, p58). Instead of an effective medium through which managers could be held accountable, hospital reports appear more like an 'exercise in public relations rather than a strong safeguard against corruption and malpractice' (Borsay, 1991b, p294). A hospital's annual reports were filled with the evidence of its success, and listed alongside were the names of the great and good supporters, who by the provision of their time, and/or their money, had created and maintained the noble institution.

[8] Hospitals are held to have manipulated these figures by refusing to admit anyone who was chronically ill. By only accepting acute patients who had a reasonable chance of recovery, hospitals were able to present figures that implied impressive cure rates. These were improved still further by adopting the discharge from hospital of anyone deemed 'incapable of further benefit', (see for example, Abel-Smith, 1964).

Tab. 3.2: Statement of Patients from the Year 1805

Abstract of Patients

Received into the Royal Infirmary of Edinburgh during the year 1805

Patients in the Hospital, 1st January 1805			169
Admitted during the year 1805			1934
			2103
Of whom were dismissed	Cured	1504	
	Relieved	122	
	With Advice	34	
	As Improper	62	
	As Irregular	15	
	By Desire	103	
	Died	83	
Remaining 1st January 1806		180	
			2103

Source: ***Annual Report of the RIE, 1806***

3.3.2 Accountability Reversed

In times of financial crisis the annual reports of the voluntary hospitals became much more than a mere public relations exercise. Forced by necessity to examine their sources of funding, hospital managers chose to invert the purported function of the reports, from a source of information about the internal management of the hospital, to a source of information about those external to it. A particular problem was the tendency of some 'subscribers' to subscribe to a hospital, thus ensuring that their names appeared in the list of subscribers, but then subsequently, failing to pay. Initially managers were reluctant to act other than to refer to the deplorable existence of non-payers, but the repeated non-payment by a small minority ultimately so infuriated managers that they resolved to act. The exact origin of the practice is unknown, but at Bath in 1765, 'tardy payers were threatened with public disclosure when the Weekly Committee decided to copy

the practice of the Gloucester Infirmary and circulate Hospital accounts to every governor and subscriber with a list of arrears appended' (Borsay, 1991a, p213). At Salop, in 1773, the Governors introduced the 'double line system' whereby the list of names appeared beside two columns, one for subscriptions duly paid, the other for subscriptions in arrears[9], effectively producing a statement, showing the false friends of the hospital; those who wished to be portrayed as humanitarian and benevolent, but were unwilling to part with the cash.

Those named in this procedure were said to be furious and Howie refers to the 'outburst of indignation on the part of some of the subscribers thus publicly disgraced' (Howie, 1963, p134). But, nevertheless, the technique proved effective. Having found themselves the subject of a report, the recalcitrant subscribers either, paid up, or requested that their names be removed from the list, thereby removing the problem of subscriptions in arrears. However, despite the success of this approach, its effectiveness was limited to those already committed, at least on paper, to the support of the institution. While the collection of back subscriptions improved the cash flow of the hospitals, it did nothing to create an increase in funding, a particular problem during periods of price inflation, such as that which occurred during the Napoleonic wars, or during the intermittent epidemics of fever, that swept through urban and rural areas alike (Trail, 1964, p242). Aligned with this was the increase in pressure on hospital accommodation and resources that accompanied the rapid increase in population through the second-half of the eigh-

[9] the number of years that the subscription had fallen into arrears was shown in a third column

teenth and the whole of the nineteenth centuries. Hospital managers, overwhelmed by wave after wave of epidemic fever patients, found that each time, as the fever receded and the pressure on beds eased, the numbers of patients attending the hospital through more regular complaints had increased, bringing a constantly rising pressure on resources that showed no sign of abating. By the second half of the nineteenth century, many hospitals were in crisis, closing wards in order to conserve funds and seeking new sources of income, wherever they could be obtained, whilst simultaneously avoiding the spectre of state aid, the antithesis of voluntarism.

Collectors were regularly sent round the more affluent districts of towns and cities, soliciting subscriptions or other contributions wherever they could find them, but their efforts were often rewarded with one-off payments, requiring the same process to be undergone the following year. The process was uncertain, dependant on the whim of the potential contributor and of the persuasive abilities of the collector. In the first half of the nineteenth century one hospital, caught between the twin pressures of fever epidemics and population growth, responded to this situation by placing their solicitation of donations onto a more systematic footing. Over a number of years the managers of the Royal Infirmary of Edinburgh (RIE) developed, through the medium of the annual report, a system through which they created fields of visibility of the activities of contributors, enabling them to assess the extent and source of contributions and thereby target their fundraising efforts more effectively onto those sectors of the population that were deemed to be donating less than they ought.

3.4 The Royal Infirmary of Edinburgh and the Systematic Reversal of Accountability

By the early 19th-century, The Royal Infirmary at Edinburgh was held by many to be the greatest hospital in the western world[10]. Marked out by its association with the Edinburgh medical school and used on a daily basis for the teaching of medical students through clinical lectures and ward rounds, the Infirmary at Edinburgh had developed an unparalleled reputation, as the leading centre for clinical treatment and research[11]. As such, the hospital attracted patients, not only from the local area, but also from all over Scotland, the rest of the British Isles and even foreign countries. Throughout the eighteenth century, the hospital had survived relatively comfortably by the receipt of informal contributions, payments from medical students, legacies and bequests and income from investments. However, the period of inflation during the Napoleonic wars persuaded the managers that greater resources were required if the hospital were to be properly maintained. In 1802, the annual report stated that the managers 'are unanimously of opinion, that they ought not to permit the benefits of this Institution to be abridged without stating publicly its situation, and giving an opportunity to the opulent and humane to contribute to its support' (p4). Seeking greater constancy of income, the managers initiated

[10] If the greatness of a hospital could be defined by the number of histories that have been written about it then the RIE would certainly have to be ranked amongst the greatest. See, for example, the administrative histories by Steedman (1778), Thin (1927), Logan Turner (1929), Gibson (1948) and Catford (1984), or the (arguably more interesting) works that include discussions of the nature of hospital life in the 18th and 19th centuries by Risse (1986), Goldman (1987) and Yule (1999).

[11] The highly trained graduates of the Edinburgh medical school provided a serious challenge to less well trained English physicians and were often involved in radical attempts to reform medical practice and corporations in England (Waddington, 1973: Pickstone and Butler, 1984)

'after the example of various charities in England' a scheme 'of the Subscription of small sums of money' which appeared to be 'the only effectual mode of securing the permanency of this excellent Institution' (p5). Concerned that they may set 'bounds on the benevolence' of potential contributors, the managers nevertheless fixed the rate of subscription at a sum 'not less than Half-a-Guinea nor higher than One Guinea, yearly' (p5) and the lists of subscribers, were organized alphabetically and according to the amount subscribed. This system appears to have served the Infirmary well, until the first major fever epidemic in 1817.

3.4.1 Epidemics and the Establishment of Subscriptions

By the 18th-century the great pandemic plagues had ceased to sweep through European populations. Improved travel and increased population density in towns and cities meant that fevers were endemic, constantly present, particularly amongst the poor sections of the community (Woodward, 1974). By the 19th-century as population densities increased still further and sanitary and living conditions deteriorated markedly, fever epidemics began to break out in the major towns and cities, affecting all sections of the population, regardless of wealth or social status. The treatment of fevers had long been a priority of voluntary hospitals, but with a flawed understanding of the causes of the spread of disease and sickness, little significant progress had been made. When an epidemic broke out civic authorities could do little and citizens had to rely upon voluntary hospitals for treatment, which consisted mainly of isolation in a ward allocated to fever patients (Porter,

1993). At such times, the burden on the voluntary hospitals was great, as the number of patients increased, so did the proportionate cost of their maintenance and hospital managers were typically forced to appeal to the citizenry for additional funds. Understandably, many wealthy people were very keen to ensure that poor fever victims could be accommodated by the hospital, thus reducing the potential for the epidemic to spread into the more affluent districts of the town. The injection of cash received by the hospital was often so great that the managers found themselves with a significant surplus, an embarrassment that they generally tried to avoid, as it had a negative effect on future fundraising efforts.

In the aftermath of 1817, the year of the first great fever epidemic in Edinburgh, the Infirmary's managers found themselves, after an appeal for funds, in the awkward position of having too much cash. To reduce the surplus they carried out 'certain improvements connected with the infirmary, and which the increase of ... revenue now for the first time enabled them to accomplish' (Annual Report, 1819, p5). This action enabled the managers to claim that they were 'unable, from the increased demands for admission into the hospital, to extend ... benefits in the way they could wish without further aid from the public' and that 'while the income of the last year cannot be viewed as permanent ... by far the greater part of the expenditure ... may be at least reckoned upon as of very considerable duration' (Annual Report, 1819, p6). To address this situation, by seeking to establish contributions to the Infirmary on a more permanent basis the managers resolved:

"1st, That an application be made to the Lord Provost and Magistrates, and to the

> Clergy of the Established Church, and of other churches and chapels in this city and its vicinity, for a general collection at the church doors, requesting that they would at the same time be pleased to recommend to their respective congregations the propriety of contributing towards the funds of this important charity.
>
> 2dly, That a subscription book be sent round to all houses in this city and its immediate vicinity, so as to afford a more ready opportunity to the inhabitants to contribute to the charity.
>
> 3dly, That application be made to counties and to parishes in use to send patients to the hospital, or which may be otherwise disposed to contribute its funds.
>
> 4thly, That a detailed account of the proceedings connected with the management of this charity during the last year be printed and circulated for the information of all parties interested in it." (Annual Report, 1819, p14)

As will be seen, by adopting these measures the managers effected a significant increase in the income of the Infirmary. As fevers continued to break out periodically over the next 20 years the managers constantly reminded the public of the way in which the hospital 'prevented the extension of the disease to very numerous individuals, who must otherwise have suffered from it, and stayed the progress of a calamity' (Annual Report, 1837, p5). If the public failed to 'come forward and contribute liberally' then, the managers threatened that 'they may, in a short time, be under the painful necessity of shutting up the spare wards, ... and in that case there is every reason to apprehend that the diffusion of fever through the city must very materially increase' (Annual Report, 1837, p6). In these fundraising drives, the managers were supported wholeheartedly by the committee formed from the Court of Contributors to report on the activities of the hospital's management. Each year this Committee of Contributors would write a report on the state of the management and finances of the hospital and this document would be included in the published annual reports.

Backing the claim that 'fever would now have been much more extensively prevalent had it not been for the exertions of the Managers' the Committee of Contributors urged 'the paramount necessity of using every exertion to increase the resources of the Infirmary'. Should the public fail to come forth with sufficient funds, the committee warned that 'It may then become a subject of deep regret to many that they omitted the opportunity of contributing, at so little cost, to arrest a contagion at its origin, which after it has obtained its full malignity, it may be impossible to subdue, and which may bring along with it such wide-spread affliction throughout all ranks of society' (Report of the Committee of Contributors, 1837, p10).

3.4.2 The Committee of Contributors

During this time a strong alliance developed between the Committee of Management and the Committee of Contributors in which the latter began committedly to exert itself in favour of efforts to raise new funds for the hospital. Critique of expenditure was markedly absent and management efforts were typically referred to as 'judicious and efficient'. Allusions were made to the consequences of not ensuring sufficient medical provision. 'Under a proper system of medical police,' argued the committee, 'it may be considered that a Fever Hospital should be provided and maintained at the expense of the community, independently of the aid to be derived from private endowments, or voluntary contributions'. Raising the spectre of an assessment upon the community they claimed that 'Upon enlightened

principles, it would seem to follow that the public should be equally compelled to provide for the necessary repression of infectious disease, as for the punishment of crime' (Report of the Committee of Contributors, 1838, p10). To avoid the undesirable outcome of compulsory taxation to pay for an inefficient publicly run fever hospital the wealthy would have to reassess their philanthropic credentials and provide additional funding for the 'efficient' voluntary institution:

> "Perhaps this very law of society is a dispensation of Providence for enforcing more powerfully the obligations of compassion and beneficence ; and it ought to be a source of satisfaction to the comparatively wealthy, that they may thus at once consult the temporal welfare of themselves and families, and discharge those duties to the poor which are among the most essential and conspicuous parts of Christian charity" (Report of the Committee of Contributors, 1838, p11).

The role of the Committee of Contributors was strengthened in 1840, when concern began to be raised about the way in which contributions to the hospital dropped significantly in years when the fever had abated. At a public meeting on the 1st of February, 1841, one Mr. Patrick Robertson moved a resolution 'to the effect of impressing on the public of Edinburgh, and of Scotland in General, the necessity not merely of affording temporary relief, *but of making annual and permanent contributions to this Institution*' (original emphasis). The motion was carried and Mr Learmonth moved that 'a Committee be appointed to carry that resolution into effect' (proceedings of a public meeting on the 1st of February 1841, LHB1/4/40). While this was also agreed to and a committee appointed, its role was immediately assumed by the Committee of Contributors who began to pursue this objective with great vigour. 'What is essential for an establishment of this

nature is a steady and constant flow of contributions, proceeding not from a casual or transient impulse, but from deep and steady principles of Christian duty and philanthropy' argued the contributors later that year, as they began to question the quality of the philanthropic credentials of those whose names appeared on the lists (Report of the Committee of Contributors, 1841, p12). Reinforcing this message the Committee stated that 'contributions ought, to be of as large an amount as may be consistent with the means of the contributors, and with the other conflicting claims to which they are exposed' (p12), thereby introducing the concept that the quality of an individual's philanthropy was linked to that fraction of their disposable income that was devoted to the cause. To increase the visibility of the appeal, individuals such as the 'Commissioners of Police and other official persons' were recruited and allocated to 'small districts of the town' where they might endeavour to 'obtain as great a number of contributions and subscriptions as possible' (p13). Simultaneously, the Committee began systematically to analyze the expenditure of the hospital in an attempt to establish its needs.

3.4.3 The Normalization of Revenue and Expenditure

Aware of the tendency of the public's enthusiasm to fade in the wake of a large appeal during a fever epidemic, the managers began in non fever years to highlight the 'falling off in all the sources of Ordinary Revenue with the exception of the Subscription Contributions, which have increased considerably' (Annual Report, 1842, p7). Deeming that 'the urgent appeals which it was necessary to make in

behalf of the Fever Hospitals must, in some degree, have interfered with the ordinary contributions to the Royal Infirmary' (Annual Report, 1843, p5) obscuring the financial position of the hospital, operating under normal conditions, the managers decided to separate the different forms of income:

> "The whole of the large fund which has been raised for the Fever Hospital has been exclusively set apart for that purpose, and that all the accounts connected with this extra expense have been kept separate from the ordinary expenditure of the Infirmary, and will shortly be published in a separate form, so that the Royal Infirmary in its own proper department, will derive no benefit from that fund." (Annual Report, 1843, p5)

In support of this the managers also calculated a figure for the 'normal' number of fever patients, based upon the average in non-epidemic years, and recalculated the statement of patients with the excess removed to allow for a more 'proper' analysis of expenditure. This done the managers renewed their appeal for more consistent regular donation, confident that 'the Public will bear in mind, that, while a visitation of providence has rendered an extraordinary call upon their benevolence necessary, there remains an undiminished call for the exercise of their charity' and hoped that 'this Great National Hospital, ere long, ..., will also be supported by a much larger number of regular annual subscribers' (Annual Report, 1843, p6).

While contributions did indeed increase steadily over this period they were struggling to cope with the increased pressure on beds, which was causing a steady rise in the hospital's daily running costs. For some time the managers had been diverting funds from legacies and bequests to cover the normal running costs of the institution, a situation held to be most undesirable:

> "From the Abstract of the Accounts herewith produced, it will be seen that the revenue during the past year was L.6,856 : 14 : 3 , and that the expenditure was L.7,810 : 8 : 2 , thus shewing a balance of expenditure exceeding the revenue of L.953 : 13 : 10 ; so that it is only by applying a portion of the legacies and donations received during the above period that the Managers have been able to provide for the deficiency in the ordinary revenue of the year. With a view to the permanence and efficiency of the charity, it is most desirable that the necessity for this should, if possible, be avoided ; and, therefore, the Managers trust that the Contributions to the Infirmary will not only be continued, but increased" (Annual Report, 1845, p4).

The Committee of contributors decided to pursue this analysis further by breaking the expenditure and revenue down into that which was 'permanent' and that which was 'fluctuating'. Taking the Expenditure first, the Committee argued that the fluctuating 'embraces those matters which more immediately relate to the object of the Charity, [such] as Utensils, Maintenance, Apothecaries' Shop, Salaries, Coals, Gas, and Incidental Expenses', while the permanent expenditure included 'payments of Feu-duties, Annuities, Interest, and Repairs of the Building'. Turning to the revenues they decided that the permanent was 'that derived from the interests of Bonds, Dividends, Feu-duties, and Rents', while the '*Fluctuating Revenue* is derived chiefly from Subscriptions, Contributions, Collections at Churches, Fees from Students and other minor sources' (emphasis in original). While noting that the permanent revenue had produced a surplus over permanent expenditure of 'about L.400', the Committee were more at pains to highlight the fact that there was 'on the Fluctuating department a deficiency of L.1255 : 2 : 0'. Bemoaning the fact that the deficit had to be made up from legacies and large donations which 'ought properly to be added to the Capital Stock, in order to produce a permanent Revenue'. The Committee explained that 'this state of matters has induced us to

look with anxiety to the Revenue, and more especially to that part of the Fluctuating Branch arising from Subscription Contributions and Church Collections' (Report of the Committee of Contributors, 1845, pp5-7).

Overall the strategy of identifying the niggardly was a delicate one for the Committee: any attempts to point the finger directly at individuals were likely to be met with outrage as the offended parties claimed their right to choose, not only the act of charity, but also its scale and direction. Any charity overly belligerent in its collection methods would have fared rather worse in the long term as damage to its reputation would turn off existing contributions as well as new ones. The line was a difficult one for the Committee and the Managers to walk, seeking as they did to maximize the possible contributions while simultaneously maintaining the image of the 'great national institution' that they represented. As a result, they chose to devise methods whereby they could present the potential of individuals to contribute while simultaneously making it clear that they had not yet done so.

To this end the Committee had described the potential of their primary target source of revenue; the citizens of Edinburgh and the neighbouring port of Leith. Considering the scale of the towns the Committee observed that 'when we consider that the population of Edinburgh is 133,000 and the inhabited houses 22,500 and that the population of Leith is 26,000 and the inhabited houses 4600-making ... a total population of about 160,000 and 27,000 inhabited houses it is surprising and much to be lamented that the Subscription Contributors above 5s. are under

1800 and that the Contributions are under L.3000' (Report of the Committee of Contributors, 1841, p7). In stating this the Committee implied that there were large numbers of non-contributors and that donations of less than five shillings were indicative of a less than prosperous, or perhaps even niggardly, individual. Either way those who had contributed more than five shillings were cast in the best light while those who had not, were cast in a rather less flattering light. The consequences of this may have had a more significant effect on the lives of some as the Committee had drawn the subject to the attention of 'the Magistrates and Council of Edinburgh, as well as Leith, accompanied with a circular specially calling their attention to [its] importance' (Report of the Committee of Contributors, 1844, p8). The difficulties of an individual who found himself before the magistrate, or seeking some favour from the council were only likely to be increased should the authorities discern that he was of a less than benevolent nature, especially if it was well within his gift.

3.4.4 The Geographical Division of Philanthropy

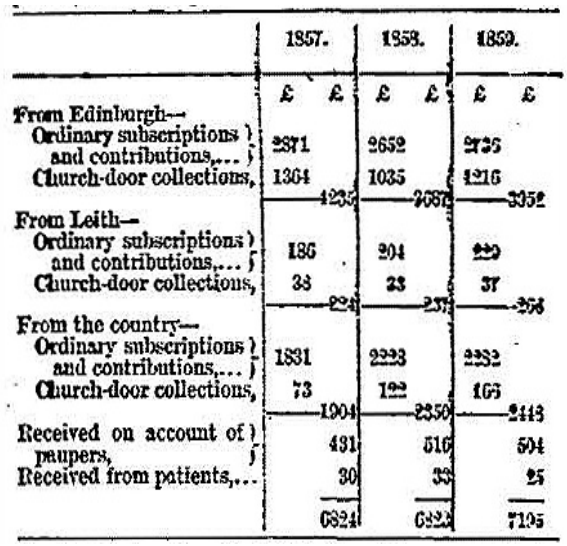
The first target for the attention of the Committee of Contributors was the discrepancy between the number of patients sent to the Infirmary from areas outside the City of Edinburgh and the amount of donations received from that source. The Committee observed that although 'there has been an increase in the contributions from country parishes . . . the sums contributed in that manner are far short of what they ought to be ; and a number of parishes have sent no contribution at all, though

the Infirmary is resorted to by patients from every district in Scotland' (Report of the Committee of Contributors, 1841, p13). Deeming the distribution of benefit and contribution to be an unfair one the Committee began to act to remedy the shortcoming. They decreed that 'states be made out of the subscriptions from each parish for the past year, with lists of the parishes that have not subscribed ; and that the Report of the Managers and Contributors should be widely circulated[12] in the country and particularly among the Convenors and Commissioners of Supply of counties, and among the clergy of all denominations' (Report of the Committee of Contributors, 1841, p13). Thus, the Committee began to publish statements in the Annual Reports that showed many parishes in a less than favourable light and thereby encouraged the more prosperous residents of those locales to contribute more to avoid being labelled as uncharitable.

The Committee sustained its efforts, by means of these statements, to increase the contributions from those country parishes that had 'never borne a fair proportion to the advantages derived by them' (Report of the Committee of Contributors, 1841, p11). By 1845 the Managers were able to note with some satisfaction that 'The contributions in aid of the Funds of the Institution, both from the town and the country around, have increased, by means of a more general application to all classes of the community for subscriptions' (Annual Report, 1845, p3). The

[12] That sufficient reports were printed for wide circulation is not in doubt. The report of 1845 explains that 'estimates were obtained for printing the Annual Report from different printers, and that a contract was made, by which 10,000 copies, including paper, were undertaken to be supplied for £51, being a fraction more than a penny a copy-a sum which we think is the reverse of extravagant' (Annual Report, 1845, p6).

creation of tabular statements that had segregated the contributors geographically and had made visible those areas that were quick to use the hospital, but slow to contribute, called into question the philanthropic credentials of those communities.



	1857.		1858.		1859.	
	£	£	£	£	£	£
From Edinburgh—						
Ordinary subscriptions and contributions,...	2371		2652		2736	
Church-door collections,	1364		1035		1216	
		1235		2687		3952
From Leith—						
Ordinary subscriptions and contributions,...	186		204		220	
Church-door collections,	38		33		37	
		224		237		258
From the country—						
Ordinary subscriptions and contributions,...	1831		2223		2332	
Church-door collections,	73		122		166	
		1904		2350		2448
Received on account of paupers,		491		516		504
Received from patients,...		30		33		25
		6824		6822		7195

Fig. 3.3: **Extract of an article in *The Scotsman* from January 3rd 1860 showing an analysis of the income of the RIE.**

The compilers of the annual reports were quick to extend their analysis into the city of Edinburgh itself and were increasingly at the centre of a sophisticated information gathering system. Individual contributions saw the philanthropist placed not in an alphabetical list, alongside the great and good whose surname happened to begin with the same letter, but, in a document that divided both the country and the city into areas and the areas into streets, with the house number appearing beside each name. The individual could view with satisfaction his efforts, against those of his neighbours, or, equally be faced with the embarrassment that those around him were more generous than he. As he walked past the collecting tin at his place of worship, the thought must have crossed his mind that the collection

would affect the reputation of his Church as it appeared in the next issue of the report. The extent of the distribution of thousands of annual reports each year made it easy for all and sundry to cast judgment on the character of neighbours, friends and foes alike.

For the hospital, the results seemed only positive. In a circular sent round the city in the Spring of 1846 the Managers pronounced their satisfaction and announced that they had 'resolved to continue the extensive and systematic mode of collecting Subscriptions throughout the whole of the City and Suburbs'. They commented effusively that: 'when the Managers consider the success which followed the general mode of soliciting Subscriptions last year, they trust that the inhabitants have only again to be waited upon, to induce them to subscribe for the support of the Royal Infirmary with that liberality which its wants demand, and to which its acknowledged value justly entitles it'. Drawing attention yet again to the 'deficiency of the income' the Managers hoped that the reader would add his name 'to the supporters of this great National as well as Local Charity' (Circular distributed in Edinburgh, March 1846, LHB1/4/45). The circular concluded with a note that the 'Collector' would call at each house, a message that began to appear with great regularity as the managers assured the recipients of annual reports, with a line on the front cover, that 'The Collector will call with the Subscription-Book in the course of a few days after the delivery of this Report'. Thus, flushed with the success of their system, the managers agreed to establish it on a more permanent basis and even to extend its scope. But, geographical separation was not the only

means of division devised by the committee. The Committee also turned their attention to the collections made at city church-doors.

3.4.5 The Social Division of Philanthropy

In particular, attention was directed at certain congregations that are regarded as being negligent in their philanthropic duty. The annual report of 1843 had noted that 'several, both Established and Dissenting congregations connected with Edinburgh, have had no collection in aid of the Infirmary during the past year.' Despite their aggrieved tone, the committee refrained from naming any of the offenders and decided simply that, 'a copy of the Report should be sent to the Session or Vestry of every Congregation within the County of Edinburgh' (p9). Certain groups failed to respond to this prompting. Some, notably the Methodists, seldom exercised their charity beyond the bounds of their own religion. To the righteous Committee of Contributors the failure to respond was unacceptable and the appropriate response seemed clear:

> "we would suggest as expedient that a classified list of the churches in Edinburgh and Leith, as appearing in the Edinburgh Almanac, should be appended to the Annual State by the Managers ; that the sums collected by each Church should be filled in, while any Church which had not collected should be left with a blank, and that the total remitted by each class should be summed up separately" (Report of the Committee of Contributors, 1845, p8)

Thus, the offending congregations and religious denominations had their lack of charity laid out in a table for all to see, while those more pious groups could equally be displayed in all their righteousness. The power of this statement was

rapidly perceived and its range was quickly extended as the Committee hoped that 'contributions more liberal from counties and more distant parishes who do now contribute will be received, and that counties, and parishes in those counties, which do not contribute, will see the propriety of contributing' (Report of the Committee of Contributors, 1846, p4), an implied threat that must have given more than a twinge of anxiety to many a rural cleric. Yet, even while this examination of religious benevolence was occurring the committee were turning their attention to yet another social grouping: the trades people.

3.4.6 The Capture of the Working Classes

For many, the voluntary hospitals had been established to provide succour to such as tradesmen, in order to prevent them falling into destitution as a result of illness or injury. But, as populations grew and, for many, prosperity increased, the Committee felt that many people were in a position to make some donation, however small, in return for the services that they had received. 'In order still more to exhibit the benefits of the institution and to encourage contributions', argued the Committee in 1845, 'we think it might be expedient, besides giving the number of patients, to specify the sexes and also the classes to which they belong, such as labourers, domestic servants, shoemakers, &c.' (Report of the Committee of Contributors, 1845, p9). With the publication of this statement in the report of 1845 the Committee began to change the character of funding at the Edinburgh Royal Infirmary and with it the nature of the hospital itself. Less now a great

symbol of upper-class paternalistic benevolence and more, as Victorian discourses of self-help and self-reliance begin to emerge, a medium through which the working classes can begin to exercise their own philanthropy and seek to obtain a level of piety previously unavailable to them. As the working classes responded eagerly to the call made by the Committee, little did they realize that they were placing themselves under the scrutiny of the annual reports.

Pleased with the response that they had received from the working classes to their appeal, the Committee decided that it might be 'expedient to circulate a short Address among the working classes, explaining to them the advantages they may derive from the Institution in case of sickness, and urging them to contribute either individually or in union with others, by the formation of Auxiliary Societies'. To promote the idea of collective donations the Committee produced an account of the various trades that were in regular receipt of treatment at the hospital, including '35 Bakers, 21 Cabinetmakers, ..., 130 Tailors, besides great numbers of other trades and occupations, unnecessary to be detailed' (Report of the Committee of Contributors, 1848, p14). In April 1847 a meeting was held by representatives of the working classes that recognized the 'great benefits derived by the whole community from the Royal Infirmary, and the desirableness that the efficiency of this noble Institution should not be allowed in any manner to decline' and that 'a united effort ought to be made, amongst both Employers, Artizans, and others, to organize amongst themselves some permanent method of contributing to its Funds, with the ultimate view of placing the Infirmary in a position independent

of uncertain and solicited assistance' (Minutes of a Public Meeting held at the Waterloo Rooms on April 5th, 1879). So, in various locations, across numerous industries, workplace collections were organized in support of the hospital.

The response of the trades people was deemed by the Managers to 'deserve especial notice'. In particular they claimed that the working men sought not only to provide for themselves should they 'require or receive benefits', but were 'providing a home in sickness for their brother-labourers' thus ascribing motives, that combine class conciousness, self-reliance and philanthropy to the working class contributors (Annual Report, 1849, p5). The efforts of the working class contributors found equal favour with the Committee of Contributors as they observed that 'the claims of the Infirmary were no sooner brought under the notice of the Working-Classes than they at once evinced the interest they felt in the prosperity of the Institution, by taking immediate and energetic steps for raising contributions among themselves in aid of its funds'. But, at the same time, they revealed that their long term expectations for this source of revenue were much higher as they anticipated that 'when the movement has had more time to extend more fully over both town and country, the amount may be expected to be greatly increased'. The benefits for the working man reached far beyond the mere ability to gain physical relief from suffering argued the Committee as increased support for the Infirmary would 'tend ... to counteract the injurious effect of our Poor-Law, which, in relieving distress, destroys the independence of the labouring man who is so unfortunate as to be compelled to receive its aid' (Report of the Committee of Contributors, 1848, pp9-

10). Thus, as the working classes dug deep into their pockets to fund the hospital in the hope of increased independence, status and spiritual improvement, their efforts found their way into the annual reports, categorized by industry, and/or trade grouping, and exposed to the same kind of analysis that took place on the charitable mores of their social betters.

Initially, the Managers and the Committee had nothing but praise for the working class campaign, but, as a result of demographic changes and technological advances that allowed the treatment of more chronic cases, the pressures on the resources of the Infirmary continued to increase. Also, the Managers found one more reason for the increasing strain; 'in the year just closed, ... [there has been] an increase of **1004** in the patients treated ... resulting, in part, from the increased and daily increasing conviction in the minds of the poorer classes in the country, of the benefits to be derived from the Institution' (Annual Report, 1851, p4). The poor, having parted with hard earned cash, to fund the hospital appeared increasingly to feel that they had a right to use it; an outcome clearly not anticipated by the Managers or the Committee.

By 1852 the Committee of Contributors were declaring that the 'Operative Classes of the Community, for whose welfare the Institution is chiefly designed, and who to so great an extent partake of its benefits, do not contribute to its funds so largely as might reasonably be expected'. They then suggested a sum at which these working class individuals might appropriately support the institution:

> "let it be supposed that, of the many thousands of operatives residing in this city and

> neighbourhood, 5000 only were contributors at the rate of one penny per week-the result would be, that the income of the Institution would be increased to the extent of L.1000 per annum and upwards" (Report of the Committee of Contributors, 1853, p13)

Seeking methods by which they could realize an increase in contributions from this area, the Committee expressed the opinion that it was not as a result of 'indifference to [the infirmary's] claims, but solely from want of an organization calculated to bring out their resources'. In this respect the system organized through the annual reports was limited, since not all potential donors could receive a copy of the report or even read it should they happen to see one. The problem for the Committee was how to bring the needs of the hospitals to bear on the groups that they wished to target. The solution was found by consulting the reports of 'similar institutions'. The 'object' they discovered 'has been accomplished [by] ... efforts on the part of Masters, Overseers, and others in Factories and Workshops, whose influence has availed to enlist the sympathies of workpeople to a large and most beneficial extent' (Report of the Committee of Contributors, 1852, p13). By the following year, however, the Committee had 'still to lament over the comparatively small amount of pecuniary aid received from the Operative Classes in support of the Infirmary'.

The proposed remedy was to form a committee that could 'put themselves in communication with the Proprietors, Managers, and Oversmen of the different workshops and manufactories in this city and neighbourhood'. By this expedient could they bring to bear their views on those parties who were in a position to

sway the opinions of the workforce. It was 'believed that a train of influences would be thus set in motion, which, in the course of time, would have a most powerful effect in calling forth the practical sympathies of the classes in question' (Report of the Committee of Contributors, 1853, pp12-13) Unwittingly, by their initial generosity and subsequent desire to use the hospital facilities more liberally, many working class citizens of Edinburgh had brought to bear upon themselves a system of collection in the confined and disciplined environment of their workplace that not only had the force of their employer's will behind it, but was prescriptive in terms of how much they should contribute.

In many ways the system of fundraising developed through the annual reports of the Royal Infirmary of Edinburgh had reached its peak around this point in the mid-1850s. The shape of the statements had stabilized and the commentary settled into a pattern of regular praise where the managers would be 'much encouraged by the result of the recent collections throughout the churches of the city' (Annual Report, 1854, p7), while the Committee of Contributors would rail that it 'cannot surely with propriety be maintained, that individuals in the receipt, it may be, of several thousand pounds per annum, should give no more than those incomes count only by as many hundreds' (Report of the Committee of Contributors, 1854, p14). The targets of praise or opprobrium would alter from year to year, but the format, despite continuous tinkering, remained broadly the same. That the system had impact is measurable: in 1837 contributions from the public amounted to some £672 . Twenty years later in 1856, they had increased incrementally

to the sum of £5771, an increase of 759% on the earlier figure. Thus had the Managers, and their collaborators in the Committee of Contributors, been able to extend their power, through the medium of the annual reports, into the city and the country beyond, invoking philanthropic motives and, latterly, themes of self-reliance and responsibility, in order to elicit increasing amounts of funding from the population. The system that they developed was enduring; still in action in the final years before the inception of the National Health Service in 1948, when the annual reports had grown to some three hundred pages in length; a dramatic change from the slim pamphlets of six to eight pages that were published early in the nineteenth century.

3.5 Discussion and Conclusion

The emergence of the voluntary hospital movement in the 18th-century, reflected a new philanthropic idealism in British society. Religious leaders, moved by the sufferings of the poor, preached doctrines of charity to the wealthier segments of society, who, in turn, responded by seeking outlets for their benevolence. Fired with promises of repayment in the afterlife and seduced by the prospect of a greatly improved image in this life, the wealthy cast around for causes that were both charitable and worthy. The voluntary hospital was an object which fitted that bill perfectly. Bolstered by the rationale of mercantile economics, the health of the nation was a subject high on the social agenda and the hospital was identified as the

most efficient method by which improvement could be realized. As the aristocratic and wealthy became involved in the foundation of these great institutions, social climbers were quick to become involved, seeking social mobility by association and through the disportment of their new-found philanthropic credentials. While involvement in a hospital offered, for many, opportunities to rub shoulders with their social betters, access to business opportunities and the chance to display their social superiority over the lower orders, it gave to all the ability to display themselves as philanthropists of high moral worth and, through the quality of their choice of charity, as intelligent, rational individuals, an image promoted by the inclusion of the names of the hospital's supporters in the annual report.

The desire of 18th and 19th century individuals to be seen as philanthropic, primarily for reasons of status and social advancement and identification, led them to place their names on the Hospital's report, thus providing them with the necessary benevolent image. The difficulty with such an act is that the individual can become trapped by it. As Roberts has observed: 'The clear recognition of self that the image calls forth offers the danger of a total identification with this image' (1991, p 357) . For the individual trapped in the image of philanthroper, it was always possible that the extent of the philanthropy could be measured by those that collected it and that the resultant knowledge could be exercised as a mechanism of power in the way that it happened in mid-19th century Edinburgh.

The annual reports were ostensibly the medium through which the hospital's

management reported on both the efficiency and the achievements of the institution. Whilst the managers had to maintain the image of an efficiently run unit, the annual reports were more often a public relations mechanism than a source of management accountability, rather, it was on occasion recalcitrant contributors who found themselves brought to account in the annual report, named and shamed as false philanthropers, unworthy of their listing. It was this potential to question the quality of an individual's commitment to the charity that was developed into a sophisticated system by the Royal Infirmary of Edinburgh.

From the above discussion it is clear that what the Committee at the RIE had developed was a system of accountability based around the annual report that created its primary fields of visibility outward from the organization rather than inwards into it. They had used these visibilities in conjunction with other analyses that could be viewed as a model of organization. The identification of the potential giving capacity of Edinburgh and Leith aligned with the structuring of costs into fixed and variable elements reflects something of the kind of analyses done by companies in the marketplace. The structuring of patterns of contributions could be seen as analogous to the maximization of revenues, or sales. But, it is the way in which these mechanisms operated that is of interest here. By taking the list of names and structuring it into organizational divisions not dissimilar to those discussed by Roberts and Scapens the hospital committee began to highlight the performance of the different sectors.

Within the confines of the city of Edinburgh the spotlight of the annual reports became intense. With 10,000 copies of the report printed annually in a city which in 1845 had 22,000 inhabited houses, all families with any significant financial means were likely to find a copy of the report on their doorstep, containing information on which houses in their street had contributed and, by omission, those which had not. In an age of close knit communities the reports were likely to be of interest to all and doubtless, most examined them assiduously to examine the extent of the benevolence of those whom they knew, whether friends, neighbours or adversaries. Also, the reports contained a comprehensive listing of all the city's churches and the extent of the collections made at their doors. Thus, the wealthier citizens had little escape from the visibility created by the reports; no sooner had the individual realized that their contribution was somewhat less than normal in the street, than the collector was at the door fully armed with the report, requesting a more sizeable donation this year.

The managers appealed to the working classes to support the institution which was held to be largely for their benefit. These people responded willingly to these calls, which promised access to both the spiritual and temporal dimensions of philanthropy and to a greater independence from the tyranny of the Poor Law. Yet, as they raised funds the workers found themselves segregated into groups in the annual reports standing one against the other in an unspoken competition to see which group was the finest fundraiser. Further, when the lower classes tried to exercise their claim to independence through a greater usage of the hospital's facilities

the managers responded to the increased pressure on resources by seeking ways to intensify collection efforts. The outcome was that employees found themselves at the end of exhortations from their employers and overseers to give more even to the point of a penny each week; a sum suggested by the Committee of Contributors in the annual report. Thus, were the managers able to create not only organizational divisions but to construct hierarchical structures of accountability that in some cases extended only from the hospital to the subscriber, via the collector, with his copy of the report, but in others reached right down into the workings of other organizations such as those in which the trades people were employed.

From the above discussion it is clear that the annual reports of the voluntary hospitals were much more than a mechanism through which subscribers to the hospital could gain accountability over the use of their funds. Rather the reports were a medium through which accountability could operate in both directions, as the managers examined the extent of the contributions that they received from the philanthropically minded. Over time the reports of the Royal Infirmary of Edinburgh developed, through the production of variously organized tabular statements of contributions, into a powerful and effective form of surveillance over the populations of Edinburgh and Leith in particular, but to some extent over the population of Scotland and beyond. Finding the quality of their philanthropy challenged, it was difficult for individuals to back out of contributing, as their names would then be omitted from the next report. For the working classes the promise of greater independence was found to be compromised as they found themselves subject to

a new form of institutionalized surveillance and demands on their resources that extended into their place of employment and perhaps even into the progression of their careers, such as they were.

4. THE LEDGERS OF DEATH: WILLIAM FARR, FLORENCE NIGHTINGALE AND THE SYSTEM OF UNIFORM HOSPITAL STATISTICS

> "It may seem a strange principle to enunciate as the very first requirement in a hospital that it should do the sick no harm. It is quite necessary, nevertheless, to lay down such a principle, because the actual mortality *in* hospitals, especially in those of large crowded cities, is very much higher than any calculation founded on the mortality of the same class of diseases among patients treated *out of* hospital would lead us to expect" (Nightingale, 1863, piii, original emphasis).

4.1 Introduction

The previous chapter assessed the deployment of annual reports by voluntary hospitals and, in particular the way in which the Royal Infirmary of Edinburgh was able to use annual reports to, counterintuitively, make the funders of the hospital accountable to the hospital, rather than vice-versa. The RIE was able to use the reports to make visible that portion of the population that was contributing to the hospital's activities and, by default that portion which was not. Through this mechanism they were able to regulate and promote philanthropy in order to achieve constant increases in hospitals finances. What the reports seemed singularly unable to do, however, was make the hospital managers and staff genuinely

accountable for their activities. This chapter will consider an early attempt to use hospital statistical reporting to create visibility of the activities and thereby gain some measure of control over the organisation and working of British voluntary hospitals. Thus the focus of the discussion moves, in this and subsequent chapters, from the way in which hospital managers were able to observe and influence the organisation of external social spaces to attempts by those external to the hospitals to create structures of accounting and accountability through which they could manage the activities of the hospital managers. This takes the focus away from the Royal Infirmary of Edinburgh and towards voluntary hospitals more generally and the great voluntary hospitals of London in particular. These institutions were perceived by those active in 19th century reform to have special problems arising from the way that way were structured and from their mode of operation.

The chapter begins by considering the ascendancy of the medical profession through their ability to use the hospitals to acquire status and pecuniary gains by their teaching and research activities, while at the same time advancing the scientific profile of the profession. The next section will consider the way in which the unviolability of the hospitals began to be broken down discourses of criticism stemming from the inability of the majority of medical practitioners to gain access to the benefits that accrued to hospital medical staff. The following section will describe how one such malcontent, Dr William Farr, began to compile statistical data, culled from the hospitals to make comparisons and analyse the effectiveness of hospitals concerned. Then, the bolstering and development of the system through

the involvement of Florence Nightingale will be considered, while, in the final section there will be an analysis of the method by which hospital consultants, under the leadership of John Simon managed to discredit the system.

4.2 Hospital Doctors

Thus far, the discussion has focused on those who provided the funding for the voluntary hospital movement, rather than those who actually provided the services within those institutions. This section will begin to address this deficit by exploring the role of and rewards available to those doctors who, ostensibly, gave their time and efforts without remuneration to the provision of medical care to those poor unfortunates that were unlikely to be able to acquire it by any other means. The efforts made by medical men in the eighteenth and nineteenth centuries were typically described by their contemporaries as a manifestation of a philanthropic desire to relieve the ills of the poor and improve their situation, in a similar spirit to those that provided the funding. As has been shown, however, the benevolent often drew significant economic and social benefits to themselves as a result of their involvement and for the medical men the situation was little different. Through their involvement in hospitals, physicians and surgeons managed to accrue significant personal and pecuniary benefits as well as, perhaps inadvertently, changing the whole structure of medical practice and education in Britain (Porter, 1997).

When the first hospitals were founded in the eighteenth century, medical prac-

tice was highly fragmented (Waddington, 1984, 1973). The medical corporations of the physicians, surgeons and apothecaries had been established, in some cases for centuries, but still carried neither statutory nor popular authority over medical knowledge and technique. Those who could afford medical care were as likely to consult a lay practitioner as a gentleman physician, or surgeon. The choice of practitioner could be affected by factors as diverse as the patient's social rank, past experience with medicine, desired degree of control over the treatment and equally by the flexibility imparted into the treatment through the medic's desire for the fee. The attainment of a medical qualification, even from an institution as venerable as Oxford, was not necessarily enough to establish a successful practice in the days when medicine had failed to establish a coherent body of knowledge that was held to be comprehensive, effective and true (Cunningham and French, 1990).

Involvement in a voluntary hospital had, therefore, an immediate attraction for the medical men of the day. Their inclusion on the staff of such an institution marked them out as, not only benevolent and kind, but through their selection by those other worthies on the boards of management, as being amongst the leading medical practitioners of the day (Abel-Smith, 1964: Woodward, 1974). Clearly visible as the senior men in the district and supplied with significant opportunities to meet wealthy potential clients through the management and social functions of the hospital, the ramifications for the private practices of these individuals could be enormous. Indeed, it was not uncommon for the consulting physicians in particular, to achieve incomes from their private practices that ran into thousands of

pounds, even in the eighteenth century. Thus, the pecuniary gains realised by these individuals made hospital appointments highly sought after, although the selection of staff was almost invariably limited to those individuals who were fellows of the requisite medical corporations (Underhill, 1992).

A new and important dimension to the income of hospital consultants emerged with the foundation of the Royal Infirmary of Edinburgh, which was modelled on the hospital at the University of Leiden. As a result of the requirement for anyone attending Oxford and Cambridge to be a member of the Church of England, Scots seeking a university medical education before 1726 were forced to go abroad. The most popular destination was the University of Leiden where the liberal Dutch education system attracted students from all over Europe and the British Isles. Inspired by the combination of formal lectures in the university and practical training in the hospital and cognisant of the unnecessary expenditure of Scots money abroad as well as the increasing demand for medical services at home[1], several Scots doctors attempted to establish a similar system in Edinburgh and were finally successful with the establishment of the Faculty of Medicine in 1726, followed by the opening of the hospital three years later in 1729.

The opening of the hospital allowed, for the first time on British soil, student doctors to observe in practice, treatments on which previously they had only received classroom instruction. In addition the relatively large numbers of patients

[1] They were certainly also aided by the emergence of a 'scientific' culture in the city at that time (see for example (Scholnick, 1999: Bullough and Bullough, 1971)).

in the hospital, especially after the opening of the new purpose built hospital building in 1742, allowed students to gain experience of the treatment of a much larger range of illnesses than was possible under the alternative indentured apprenticeship system (Risse, 1986). Drawn by the convenience, relatively low cost[2] and flexibility of the Edinburgh degree students began to attend in large numbers, from all over the British Isles and, as the fame of Edinburgh grew (and that of Leiden declined), from all over Europe and the Americas (Booth, 2000: Hamilton, 1988). Student numbers at Edinburgh remained buoyant and throughout the eighteenth and nineteenth centuries, consultants were able to augment their private incomes from the sale of tickets to students for a course of lectures that included attendance at the ward rounds, although students had to purchase an additional ticket from the hospital to gain entry to its buildings.

The income available to those teaching in Edinburgh's Infirmary did not pass unnoticed by others working in hospitals (Cunningham and French, 1990). By 1800 medical schools had appeared at St. Bartholomews, St. Thomas's and Guy's (jointly) a the London Hospital. By 1858, there were 12 medical schools in the city and 80% of the hospitals beds were in teaching hospitals (Newman, 1964, p. 115). Growth of teaching hospitals in other cities was roughly proportional to that in London and by the mid nineteenth century all major cities had at least one such establishment. The enthusiasm for the adoption of hospitals as teaching centres can be reasonably understood when it is revealed that the potential incomes from

[2] Compared to Oxford and Cambridge

teaching was substantial. One Mr Brodie was reported in 1816 to have earned £1530 from fees paid by his students for lectures and ward rounds; a sum achieved even before the treatment of those lucrative private patients available to one in his position (Abel-Smith, 1964, p. 18). Although these pecuniary factors alone may have been enough to ensure the growth of hospitals as teaching centres for the medical profession in Britain, there was another reason.

In addition to kudos and the benefits of fee income from students, there was a third important dimension of a hospital appointment for the voluntary hospital consultant; namely that of access to large numbers of poor and relatively malleable patients for research purposes. The presence of large numbers of patients in one building allowed for the classification of cases and the ability to study nuance and variation from the typical perception of certain forms of disease. Doctors were able to experiment with different forms of treatment and 'if an experiment failed, at least there would not be repercussions on the doctor's private practices' (Abel-Smith, 1964, p. 18). Consultants were able to gain vast experience through observing the effects of their treatments on the poor and were able to bring that experience to their private practices, further enhancing both their reputations as superior doctors and their ability to charge hefty fees. The rewards attained by the hospital consultants, although well known to those within the profession, were less well known to those without. The public was presented with a picture of philanthropy, benevolence, altruism and the advancement of medical science, designed to maintain the image of the voluntary hospitals and those who supported them

either by provision of funds or special skill.

The stream of 'scientific' discoveries that began to pour from them in the nineteenth century further enhanced the reputation of voluntary hospitals (Morrell, 1971, 1972: Crawford, 1991: Fissell, 1991). Given the ability to conduct research on patients in the controlled conditions of the institution, hospital doctors used the opportunity to develop a normalising discourse of scientific medicine that located disease in the body, rather than viewing it as a separate entity invading the body from an external space (Foucault, 1973: Canguilhem, 1994). Developing a classificatory form of medicine in this way allowed systematic approaches to treatment research that began to produce significant advances in medical knowledge and practice by the late eighteenth century. Added to this were technical advances such as the nineteenth century introduction of anaesthesia, for example, that dramatically increased a patient's chance of surviving the shock of a surgical procedure, as well as techniques like antisepsis and the later asepsis that were founded on new medical theories like Pasteur's germ theory of infection. The originators of these discoveries received huge acclaim and often, significant honours such as a knighthood or a peerage, from the establishment. In the majority of cases major discoveries had been made while the individual was a voluntary hospital consultant. Thus, the hospitals and the doctors who worked in them were at the centre of medical advances, enhancing further their reputation in the eyes of the public and increasing the perceived importance of gaining a position in one in the eyes of the profession.

Involvement in a voluntary hospital, therefore, provided enormous benefits to those doctors fortunate enough to hold a consultants position in one and these benefits increased over the decades as the reputation of scientific medicine and, consequently, the hospitals grew. The initial status as a consultant philanthroper and the access to wealthy clientele that this provided was enhanced in later years by the addition of significant income from teaching and the access to patients that were sufficiently compliant to allow them to be used as the objects of research. Those who were responsible for major advances in medicine were occasionally the recipients of honours that lifted their status from the middle classes to the ranks of the aristocracy. In tandem with these benefits it is clear that as medical practice improved, patient care also improved to the extent that by later in the the second half of the nineteenth century, middle class patients were also beginning to seek treatment in voluntary hospitals; a mark of how the reputation of hospitals had shifted from that of institutions for the sick poor to one of places at the leading edge of healing. However, the hospitals were not without their critics. In the middle of the nineteenth century voices began to be raised against voluntary hospitals from a number of standpoints and data sets presented by the hospitals in their annual reports often formed the foundation of this attack. The next section will consider the sources of this discontent with the hospitals and their *modus operandi* in order to contextualise the use of reported data in attacks on the hospitals.

4.3 Hospital Critics

Criticism of voluntary hospitals came from a number of different sources. Certainly there had always been grumbling about the ways in which hospital funds were spent, with some individuals comparing the annual reports of different hospitals in order to determine if any inefficiency in resource usage was occurring, but the managers in general, easily dealt with such complaints. By attending to the object of the complaint and being seen to do so, managers could fairly easily quell the discontent of their subscribers. Other, more serious, sources of criticism were centred around both medical practices and access to consulting positions in the hospitals by those individuals seeking advancement in their careers and in their fortunes. This last stimulated a cacophony of criticism that opened the door to other critiques of hospitals, culminating in an attempt by some parties to exert influence over the voluntary hospital sector as a whole.

The genesis of discontent with the hospitals arose as a result of the success of the medical schools. By the early nineteenth century the schools began to train ever increasing numbers of doctors, particularly surgeons, all of whom paid large sums 'not infrequently amounting to £500' (*The Lancet*, 1896, i, p118) for the privilege. Having invested in training they expected an opportunity to engage in or create lucrative medical practices. However, the key to a really successful practice was an appointment at a hospital and, as numbers of suitably qualified candidates increased, this became increasingly difficult to secure. The difficulty was

exacerbated by the nepotistic practices of those individuals in post who would either relinquish the post only to a relative or charge exorbitant fees for an apprenticeship that would later lead to the probability of the desired position. Thus, the only people likely to secure such a position were those who were related to the incumbent or those who were wealthy enough to afford the fees. The closure around these most lucrative posts led to a growing body of discontented doctors that suffered from the misfortune of poorly connected or, insufficiently wealthy family background (Granshaw, 1992: Porter, 1982: Porter and Porter, 1989: Wear, 1992).

This discontent began to manifest itself in the form of critical discourses focused upon the medical establishment. Various incidents, sometimes violent and often involving Scots doctors, who were unable to gain membership of the London Royal Colleges by dint of their lack of Oxbridge education, highlighted the difficulties in the public mind. With the foundation of *The Lancet* in 1823 a forum emerged for these issues to be aired. The founder, one Dr. Thomas Wakley was no friend of the medical corporations and had himself been denied access to the upper echelons of the profession, as he was insufficiently wealthy to afford an apprenticeship to a leading surgeon. A close friend of Wakley's, the radical politician William Cobbett, persuaded him to found *The Lancet* and its remit was established as: working towards the reform of medicine, the rights and education of rank and file doctors and the abolition of quackery (Cassell, 1990: Hostettler, 1984).

The Lancet emerged as a radical organ in this regard. Wakley spent much

time and effort trying to secure the rights to publish medical lectures given by the prominent men of the day. Naturally, the producers of these lectures were outraged at their publication when they were charging students up to a guinea per session for attendance and Wakley suffered many hours in court on the issue. More enmity was gained with the medical establishment over Wakley's attack on nepotism in the hospitals. This was a significant point since it was the first sustained criticism of voluntary hospital practice in the public domain. Previously the status of the hospitals as great social paragons had suppressed any major criticism of them or the beneficent men who staffed them, but Wakley's campaigns in *The Lancet* gave legitimacy to critiques of hospital clinicians and, to some extent, the management of hospitals. In this way he drew attention to their deficiencies and simultaneously opened the path and provided a forum for other interested parties to examine their performance and attempt to rectify their problems.

4.4 Dr. William Farr and his Vital Statistics

One interested individual, who had no love either for hospitals or for the leading lights of the medical profession that populated them, was Dr William Farr. Farr was an unusual doctor in as much as he was the child of a farm labourer in Shropshire. He had however been lucky in his benefactors; in particular his childhood employer, Joseph Pryce, who had recognised his talents and provided him with a basic education, subsequently built on by Farr as he taught himself Latin, French,

Italian and Hebrew. Supported by Pryce, Farr studied medicine for two years at the Salop infirmary, before going to Paris to study with some of the leading clinical teachers of his day. It was in Paris that Farr was exposed to the subjects of medical statistics and hygiene, before he returned to London to attend two years of lectures at the recently founded University College. In 1832 he passed the examination of the Society of Apothecaries and attempted to establish a practice in London, but without the necessary prestigious credentials, connections, or social graces he struggled to attract lucrative patients (Eyler, 1979).

Supplementing his income with medical journalism, Farr displayed keen awareness of medicine as both a science and a social institution. Writing in 1839, he argued that:

> "The state of medical science is only one of the elements of the inquiry; for the problem is–given a certain quantity of science, how has that science been brought into contact with the people, by what class of persons, by what institutions, and with what effect" (Eyler, 1979, p. 3).

Frustrated by his inability to develop his practice, Farr found himself increasingly commissioned by Wakley for his views on the necessary restructuring of the medical profession (Halliday, 2000, p. 221) and on the potential value of medicine to society. He also founded his own (short lived) journal, the *British Annals of Medicine, Pharmacy, Vital Statistics and General Science*[3], as a rallying point for medical reform. Into this agenda, Farr inserted his belief in the importance of hygiene as a public health measure and attempted to found a science, which he

[3] The series ran weekly, for nine months from January to August 1837.

referred to as 'hygiology' (DNB). Although not insensible to the fears of the profession that improved public health may reduce the need for medical practice, Farr was relentless in its promotion:

> "Gentlemen, ... I know that our generous profession—will not, for a moment, harbour sentiments base. We exist, as a body, to promote the public health, and if the persistence of our craft is at variance with the public good, in the name of God let it be abolished,—let us betake ourselves to something else. Happily our interests are the interests of the community: in proportion to the health and strength and knowledge of England, it has flourished, and will flourish, and in its prosperity or reverses we shall participate" (Eyler, 1979, p. 7).

While such views were unlikely to win Farr friends amongst the elite of the medical profession, they appear to have brought him to the attention of significant figures in the public health movement. Arguably, the most important of these was the dictatorial chairman of the general board of health, Edwin Chadwick who led a movement for sanitary reform form the 1830s; a movement that attracted enormous support even from the highest echelons of society as they were no more able to escape the epidemics than were the poor (Wohl, 1984). Although it is recorded in the DNB that it was the influence of Sir James Clarke that secured for Farr the position of compiler of abstracts in the newly founded General Register Office, it is testament to Chadwick's regard for Farr that he claimed to have been the determining influence in his appointment (Humphreys, 1885, p. viii).

The position was, in many ways, ideally suited to Farr's abilities; within the context of the authority of the General Register Office and unimpeded by the

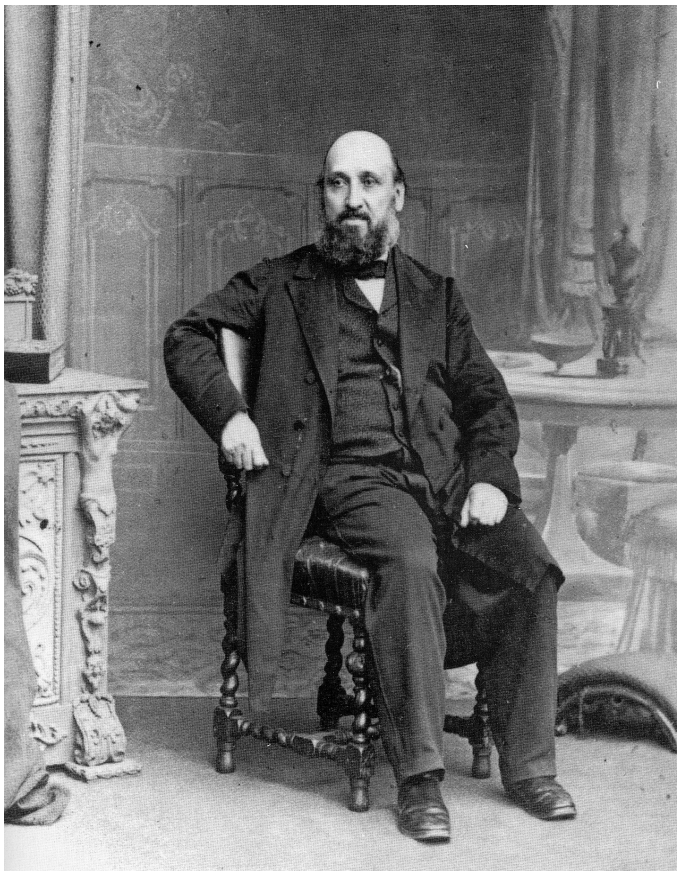


Fig. 4.1: **Dr. William Farr**

Registrar General himself [4], he was able to exercise his flair for statistics and bring to bear the truths that they revealed upon the cause of public health that he held so dear (Szreter, 1991). In this effort, and to provide the theoretical basis for his statistical investigations, Farr sought recourse in a miasmatic theory of disease transmission that was popular with many of his contemporaries (Eyler, 1973, p.85, Warner 1991). The theory proposed the existence of heavy organic

[4] In highly class-conscious Victorian society, Registrar General was a senior civil service appointment reserved for those of high social standing and unavailable to one of Farr's lowly position. This became a source of bitterness for Farr later in his life, when in 1879 he was passed over for the appointment yet again and resigned in disappointment. Nevertheless, Farr was allowed great freedom to exercise his abilities in the conduct of his work and is held to have authored the vast majority of the reports published by the Registrar General.

particles, suspended in the atmosphere and concentrated in areas of high population density:

> "Every population throws off insensibly an atmosphere of organic matter ... this atmosphere hangs over cities like a light clouded, slowly spreading, driven about, falling dispersed by the winds, washed down by showers ... to connect by a subtle, sickly medium, the people agglomerated in the narrow streets and courts, down which the wind does not blow, and upon which the sun seldom shines" (10th Annual Report of the Registrar General, 1847, p. xv)

> "This disease mist, arising from the breath of two millions of people, from open sewers and cesspools, graves and slaughter-houses, is continually kept up and undergoing changes; in one season it was pervaded by Cholera, in another by Influenza; at one time it bears Smallpox, Measles, Scarlatina and Whooping Cough among your children; at another it carries fever on its wings. Like an angel of death it has hovered for centuries over London" (10th Annual Report of the Registrar General, 1847, p. xvii)

On this basis, Farr sought to collect and compile statistics that would identify those areas where the miasma hung at its thickest and which would derive most benefit from intervention designed to alleviate the problem.

This approach associates Farr with that group of social reformers, typically utilitarian and Benthamite in their perspective[5], that perceived statistics not as a dry aggregation of data for posterity, but as a primary source of information for social intervention (Greenwood, 1948, Rosenberg 1981, p. 679, Hacking 1990,

[5] Edwin Chadwick had served as Jeremy Bentham's secretary and had assisted him in the completion of *The Constitutional Code*. That Bentham had a strong influence on Chadwick's belief in the value of statistical intervention cannot be doubted (Hume, 1970, p189), but Hamlin has argued that, although Chadwick publicly supported the miasmatic principle as a cause of disease until the end of his life, his development of it was an expedient designed to divert attention from the failure of the New Poor Law and from poverty as a cause disease (Hamlin, 1994). It is unclear whether Farr also viewed miasma as a means to an end. His resistance, however temporary, to Jon Snow's epidemiology of cholera implies that, either he did fully support the theory until convinced otherwise, or that it was simply inexpedient to abandon it at the time of Snow's discovery.

Porter 1996) . The council of the Statistical Society of London[6] in 1840 argued that:

> "By this cultivation [of statistics] only can we arrive at a knowledge of the physiology of societies, and comprehend the paroxysms of disease which they sometimes exhibit in a state of violence, or the exhilaration of health, which displays itself in a state of peace. Empirical treatment of symptoms, without this knowledge, must be as vain in its effects upon the body politic as upon the human frame; for it has no guide but "opinions," under which name may be couched the wildest or the most rational notions, the truth or fallacy of which is as yet equally unsusceptible of proof from scientific data" (JSSL, 1840, p6).

While it cannot firmly be established that he was the author of the quote, it was the kind of rhetoric typical of Farr and he almost certainly approved of its sentiment. For him, data collection was all about changing society and the conditions of its inhabitants. In communication with Florence Nightingale in 1864 he asked, 'and what are figures worth, if they do no good to men's bodies or souls[?]' (Eyler, 1979, p.197).

Within the ranks of the London Statistical Society, Farr found many sympathetic colleagues. Many medical men were involved in the statistical societies at this time and in the Royal Statistical Society of London, upwards of one third of the papers read in the 1840s were on medical and public health related problems. Amongst the targets that Farr selected for special attention by the society were the voluntary hospitals. A few years previously Farr had collected data on the hospitals based upon their reports, but the plan of the Statistical Society was more

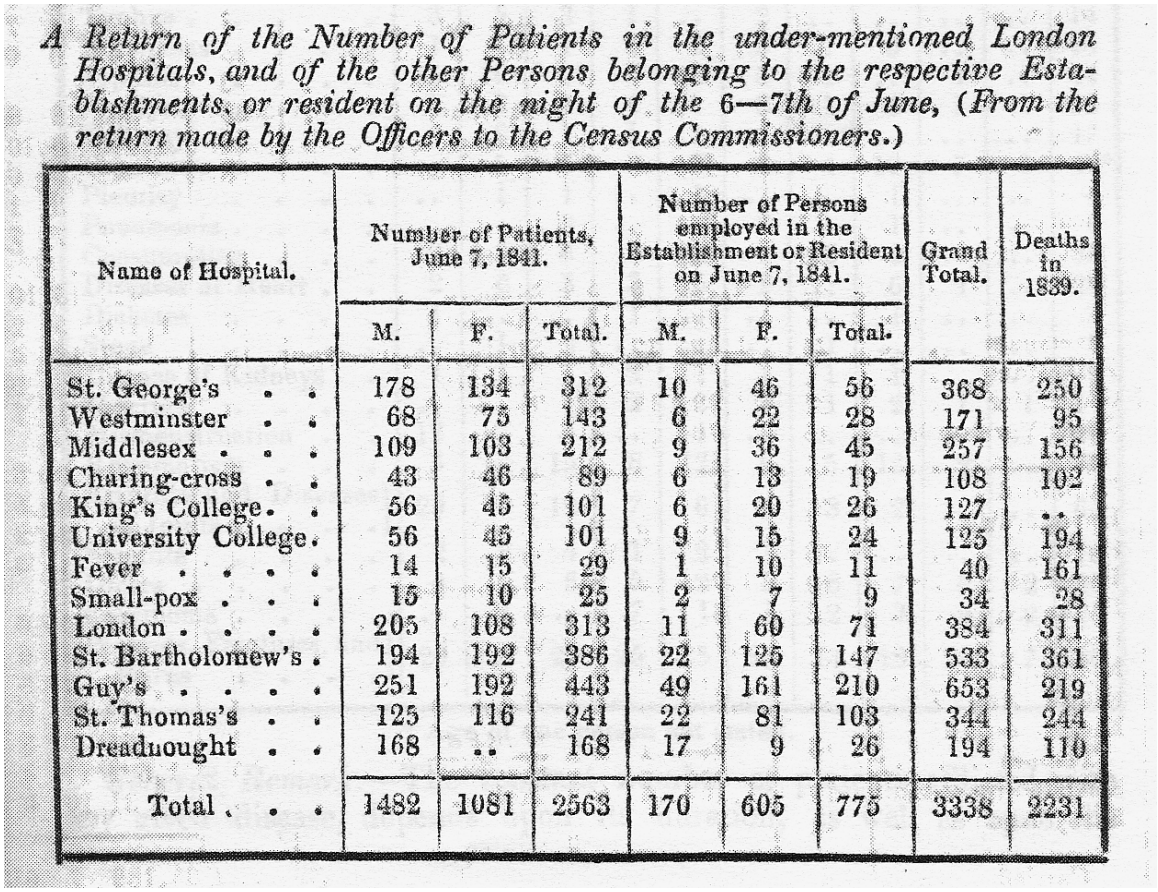
[6] Farr was heavily involved with the London Statistical Society at this time and was establishing a committee to investigate the mortality of hospitals in Britain generally, but in particular London.

ambitious. Rather than relying on the data that the hospitals deemed fit to publish, the society sought to persuade the hospitals to report on a more regular and comparable basis. *The Lancet* reported that the council of the Statistical Society had 'appointed a "Committee of Hospital Statistics," to consider the best means of collecting facts that will be susceptible of numerical analysis on an uniform plan, in periodical returns made from the various sanitary institutions of the country' (*The Lancet*, 1842, i, p476). The editorial applied a little psychology to promote compliance with the scheme:

> "Such a proposal as has been referred to above would have startled many of the bigwigged and gold-caned gentlemen of the "good old school" out of their propriety, have been regarded as the sure indication of some deep-laid conspiracy against their peace or reputation—some contrivance for surreptitiously seizing the secrets of their pharmacy or for exposing the quackery of their pretensions. Treasurers and jobbing governors would have been in arms. This is much altered now. We should not be surprised if the Committee of the Statistical Society obtained, instead of opposition, the active and intelligent co-operation of all the most enlightened men connected with our public institutions" (*The Lancet*, 1841-2, i, p477).

The purpose of this compilation, argued *The Lancet*, was the advancement of science, promoted through the analysis of large sample statistics. However, the report produced by the committee, although containing aggregated data showing the main causes of death, was fronted by a table showing the numbers of deaths in each of thirteen London hospitals. Further, the report was published not only in the Society's journal, but was also 'printed for circulation amongst the supporters and authorities of the various medical charities of the Metropolis' (JSSL, 1842, p168). Clearly, the philanthropic beneficiaries of the hospitals were unlikely to

require this information for 'scientific' purposes. For most, the only use for such a report would be to provide comparisons of the performance of the alternative institutions to which they could donate their money.



A Return of the Number of Patients in the under-mentioned London Hospitals, and of the other Persons belonging to the respective Establishments, or resident on the night of the 6—7th of June, (From the return made by the Officers to the Census Commissioners.)

Name of Hospital.	Number of Patients, June 7, 1841.			Number of Persons employed in the Establishment or Resident on June 7, 1841.			Grand Total.	Deaths in 1839.
	M.	F.	Total.	M.	F.	Total.		
St. George's . .	178	134	312	10	46	56	368	250
Westminster . .	68	75	143	6	22	28	171	95
Middlesex . . .	109	103	212	9	36	45	257	156
Charing-cross . .	43	46	89	6	13	19	108	102
King's College. .	56	45	101	6	20	26	127	..
University College.	56	45	101	9	15	24	125	194
Fever	14	15	29	1	10	11	40	161
Small-pox . . .	15	10	25	2	7	9	34	28
London	205	108	313	11	60	71	384	311
St. Bartholomew's .	194	192	386	22	125	147	533	361
Guy's	251	192	443	49	161	210	653	219
St. Thomas's . .	125	116	241	22	81	103	344	244
Dreadnought . .	168	..	168	17	9	26	194	110
Total . . .	1482	1081	2563	170	605	775	3338	2231

Fig. 4.2: **The mortality of London hospitals 1840 (JRSS, July, 1842)**

The text of the report was laced with self-propagating argument; insistent upon the value of regular and standardised reports designed to make visible the activities of the voluntary hospitals:

> "Should they [the London hospitals] act in an isolated manner, and independently of each other, or should they register the observations on a uniform system, and throw them into a common stock, to be arranged in order which may appear, when due consideration, best calculated the yield the important results to which we have above adverted?" (JSSL, 1842, p173)

> "Without some standard of comparison, ... , medical science can make a little further progress. It will be impossible to determine accurately the relative value of different methods of treatment now in use; or of any new remedies and methods of treatment, which may be discovered. Medicine will always be open to unjust charges of inutility, and the public health will be the sport of fashion, the perilous innovations of empirics, and superficial theorists." (JSSL, 1842, p173)

The committee reported that they had 'resolved, that application, by letter, be made to the boards of the hospitals respectively, on the subject of the adoption of uniform methods of registering of cases and that the sanction and support of the medical officers be requested to such applications' (JSSL, 1842, p174).

The council also proposed that a joint committee under their direction should compile the next abstract report. However, when the report was published its character was very different from that of the first (JSSL, 1844, p214). All references to and statistics of the comparative performance of hospitals had disappeared. The reason for this is not clear. Perhaps, the medical officers on the joint committee had objected to the inclusion of that type of information, or perhaps complaints had been made about its inclusion in the first report. Whatever the reason, the members of the Statistical Society abandoned the venture at this point. They hoped that they 'may have paved the way for some future arrangements by which the knowledge to be derived from these valuable schools of experience may be recorded, collected and digested' (JSSL, 1844, p217), although no attempt appears to be made by the London hospitals to develop or maintain such a system.

The outcome of these reports seems to have been to direct the attention of hos-

pital managers to the importance of their vital (death) statistics. In an editorial of 1851 *The Lancet* pointed out that there were a number of discrepancies in the recent statements of some London hospitals that were held to require further explanation. In particular they referred to 'the objectionable method pursued at some hospitals, whereby most erroneous inferences respecting the benefits conferred on the community might be deduced' (1851, i, p55). They were alluding to:

> "The mode adopted of multiplying apparently the amount of admissions, without the reality; that is, by reckoning patients who have remained more than two or three months in a particular hospital, as fresh admissions; so that one inmate may sometimes be counted as two, four, or even six cases" (*The Lancet*, 1851, i, p. 55).

By inflating the number of patients that they claimed to have treated, the hospitals were, in their annual reports, both exaggerating their success and simultaneously reducing the percentage of mortality occurring in their institutions. *The Lancet* disparagingly referred to the way in which '*post-prandial* orators' would: "descant to the governors at their "annual feed," upon the great blessings any particular charity confers upon the sick poor, if they thus announce a large array of cases admitted and cured" (1851, p. 55). Nor, they felt, was this a trivial matter. Hospital statistics and the way in which they were reported to the public seemed increasingly unreliable and needed to be placed in safer hands and collected in a more systematic, uniform way:

> "The prying eyes of the profession are now generally directed to the statistics of hospitals ... [they] should be henceforth periodically published by official authorities [which] ... ought to be arranged according to an uniform and generally adopted system ... otherwise they would prove utterly valueless,

> and frequently lead to most erroneous conclusions" (*The Lancet*, 1851, i, p. 55).

But, *The Lancet's* ambitions remained unrealized. The attention of William Farr and the Statistical Society was directed elsewhere at this time and philanthropists were left at the mercy of the unregulated reporting of the hospitals. Only very occasionally was aggregated information presented in the medical press (see for instance *The Lancet*, 1856, i, p. 55 and p. 111) and then typically extracted by some individual or other from some marginal source of information. Thus, whether they were interested in the development of scientific knowledge, or in the performance of their charitably funded institutions, reformers were disappointed. Those managing hospitals and the medical services within them had little appetite to expose their activities to comparison with other, perhaps better institutions. And, those who desired reform had insufficient influence or power to impose upon hospitals a uniform system of data collection that would allow such comparison. Hospital reporting, therefore, remained little changed throughout the 1840s and 1850s, until a chance meeting in 1856 between William Farr and Florence Nightingale generated momentum.

4.5 Florence Nightingale: The Lady with the Ledger

The meeting between Florence Nightingale[7] and William Farr at a dinner party in the autumn of 1856 was to have profound consequences for the management of hospitals in Great Britain. Recently returned from the Crimea, Nightingale had acquired the status of a national heroine and was approaching the peak of her power and influence (Woodham-Smith, 1952: Strachey, 1918). Farr was quick to recognise this, as well as her keen interest in the management of hospitals, and realised that she would be a powerful ally in his desire for hospital reform. She, in turn, recognised the value of his statistical skills and the important role that they could play in her attempts to reform army medical services. Thus, Nightingale and Farr formed a pact, each to support the other in their campaigns to introduce sanitary changes into military and civilian health services respectively.

The task for Nightingale was daunting: her ambition was no less than to revolutionise army medical care in the face of a management hidebound by centuries of aristocratic apathy and disdain. However, the magnitude of the task was unlikely to put off someone with the strength of character of Florence Nightingale. Born into a wealthy and influential family in 1820, by early adulthood Nightingale was already displaying disdain for social convention. Rejecting the path of courtship and marriage, she sought a mission in life and had apparently found it when in

[7] Recognition for the title of this section must go to Moyra Kedslie as she planned, some years ago, to use it as the title for a paper that unfortunately was never written.

Fig. 4.3: **Florence Nightingale**

1842 she wrote: 'my mind is absorbed with the idea of the sufferings of man, it besets me behind and before. ... All the people I see are eaten up with care or poverty or disease' (quoted in Everett, 1974, p13). Horrifying her family with her desire to take up nursing as a profession[8], she nevertheless pressed on, mercilessly using her father's influential friends to gain positions and experience. Her efforts were eventually recognised and rewarded with an invitation in 1854 from Sydney Herbert, then secretary of war, to take a party of female nurses to Scu-

[8] It was unheard of at this time for a well-born woman to work in nursing. The vast majority of nurses were extremely poor, uneducated, often drunk and held in very low esteem by medical professionals and public alike. In addition, nurses had little or no protection in the hospital setting from sexual predation by patients or staff. (Small, 1999)

tari[9] to alleviate the nursing and administrative problems that were causing great suffering there at that time. During the two years that she spent at Scutari, she witnessed enormous suffering as a result of repeated epidemics that swept through the hospital while she was in charge. Thousands died, but Nightingale gained a reputation for indomitable spirit in her endless battles with the army hierarchy as she tried to secure adequate supplies (Berges, 1996), and was adored by the troops for her apparently endless compassion. She decreed that no man should be left to die alone and personally spent countless nights at the bedsides of the terminally ill (Strachey, 1918: Woodham-Smith, 1952). Little wonder then, that on her return to Britain she was inflamed with a passion for the reform of hospitals and their management, but despite leaving the horrors of Scutari behind her, the affair had one final dramatic twist for Florence Nightingale.

When she enlisted the help of William Farr, she had believed that the main reason for the high mortality rates prevailing at Scutari was the unavailability and poor quality of supplies, overwork and lack of shelter. However, analysis conducted by Farr using statistics collected not only from her own hospital, but from other army hospitals in the area demonstrated that, rather than poor nutrition, which was prevalent throughout the army, it was the poor sanitation and overcrowding distinct to her hospitals that had been primarily responsible for the horrific mor-

[9] Scutari was the British name for Uskudar, a suburb of Istanbul on the Asian side of the Bosphorus, where in 1854 the British had set up an army hospital that had become notorious for poor organisation and lack of supplies through a series of highly critical articles by Thomas Chenery, Constantinople correspondent to *The Times* (Hastings, 1995, xviii). Crucially, Chenery had bemoaned the lack of an equivalent of the French Sisters of Mercy in Britain, thus offering Herbert the opportunity of sending Nightingale and her nurses on a 'respectable' mission.

tality (Small, 1999). It is clear that by 1857 she had completely accepted this verdict[10]:

> "I do not hesitate to say that the causes of the great catastrophe at Scutari were want of ventilation, want of draining, want of cleanliness (too disgusting to detail further), want of hospital comforts, frightful overcrowding. However good the construction and ventilation of the corridors, if you fill them with patients, it is the same as building to hospitals back to back. In all our experience, whether of healthy, or of sick men, such construction generates disease. And our knowledge is now somewhat absolute on these points" (quoted in Small, 1999, pp91-2).

This conclusion was particularly devastating for Nightingale, because through herculean efforts she had repeatedly extended the accommodation at Scutari and persuaded the army to send her more and more of the sick and wounded in the belief that she could provide better care than that of the army's military hospitals. In fact the reverse was true. By filling every inch of available space she had promoted the conditions that would guarantee the repeated waves of infection that swept through the cramped and insanitary buildings.

Not one to be dismayed for long, Nightingale rapidly recovered and returned to the offensive. Now, fully convinced of the rectitude of Farr's sanitary arguments, she began to reformulate the measures necessary for improvements in health of patients in hospitals and barrack buildings. Simultaneously, with the help of Farr and using the same mortality statistics with which he had convinced her, preparations were made to present the government with incontrovertible proof of the absolute necessity for the changes.

[10] Nightingale requested that all her correspondents destroy letters that they had received from her in the period immediately prior to this. Small speculates that she was destroying the evidence of her erroneous assumptions of the causes of mortality (1999, pp 92-3).

The case was presented in 1858 with the publication of *Notes on Matters Affecting the Health, Efficiency, and Hospital Administration of the British Army, Founded Chiefly on the Experience of the Late War* (Nightingale, 1858). The argument was founded upon the economics of poor health in the army during the Crimean War:

> "During this period, the average of "constantly sick" in our army was 38.9 per cent. In other words, not more than 61 per cent. of the nominal force on the plateau before Sevastopol were fit for duty. ... That is, if the besieging force actually on duty had amounted to 100,000 men, there would have been an additional 64,000 constantly in hospital, requiring an army in themselves for guarding, medical attendance, the nursing; together with an immense transport train for Hospital equipments, medicines, comforts and supplies" (Nightingale, 1858, p7).

Improvements in hospital and barrack sanitation would, she argued, drastically reduce the numbers of troops required to effectively prosecute a war. In addition, the funds required to support the necessary medical facilities would also be significantly less. With the aid of Farr, she produced powerful graphical representations[11] of the abnormal mortality caused by the appalling conditions during the Crimean War (see Figure 4.4). The government was both impressed and appalled. While accepting that changes had to be made, ministers, fearing a public backlash, were unwilling to release the report into the public domain, so the report was suppressed and the reason for the reorganisation of the army remained hidden.

[11] The extent of their collaboration on this remains unclear. The diagrams produced are often held to be the first known examples of this kind of graphical representation. That Florence Nightingale was capable of producing such an original piece seems not unlikely as she had received a full mathematical education from her father (Slater, 1994) and had developed her skills under the tutelage of Farr (Small, 1999).

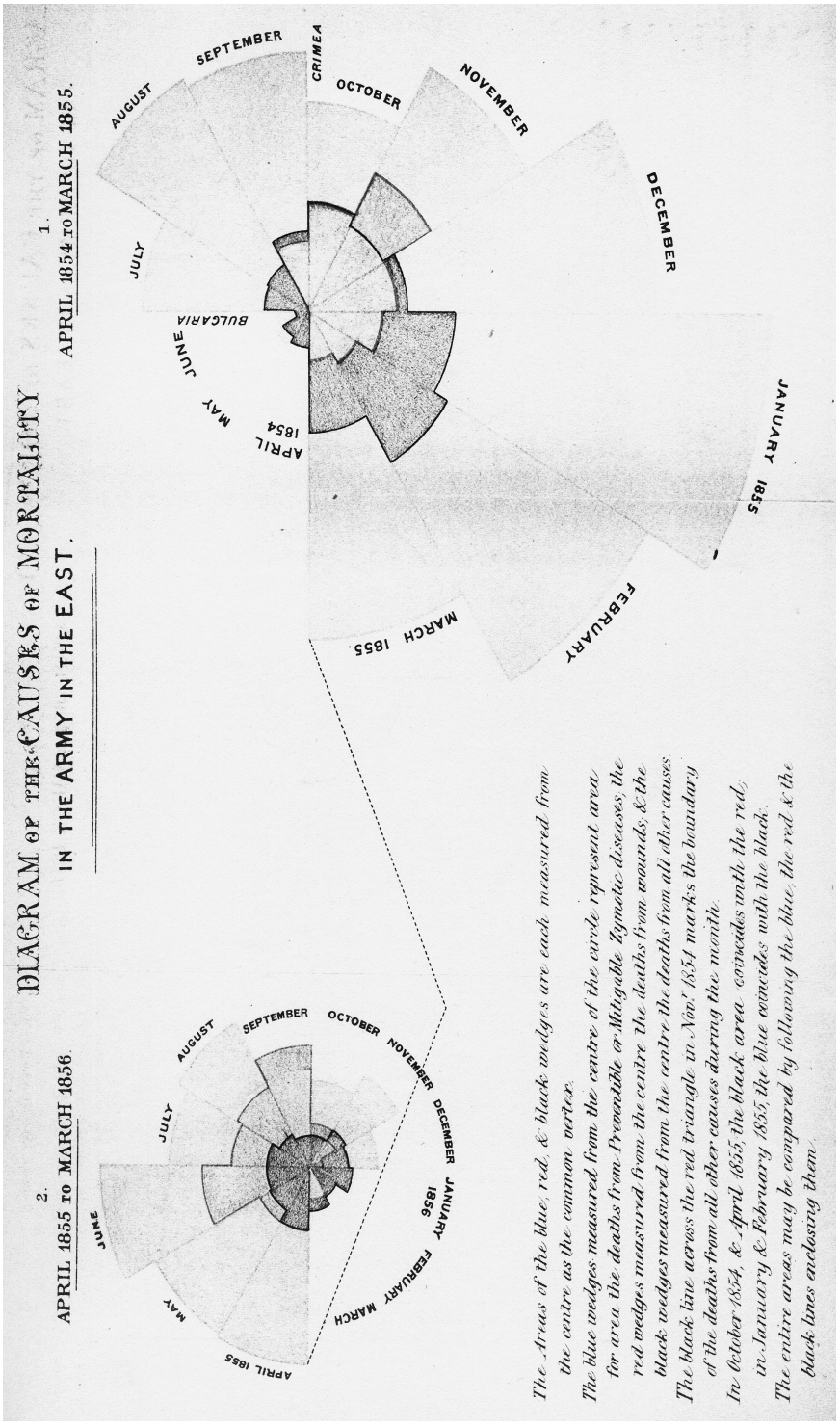


Fig. 4.4: **The Causes of Mortality in the Army in the East (From an insert in Notes on Matters Affecting the Health, Efficiency, and Hospital Administration of the British Army, Founded Chiefly on the Experience of the Late War, Nightingale, 1858)**

Nightingale was furious that the report was not to be published and began to disseminate copies subversively. She continued for many years to work for sanitary reform in the army and relentlessly applied pressure to many influential friends in powerful positions. However, her campaign to reorganise and reform the War Office foundered with the resignation and subsequent death of her devoted friend Sydney Herbert. After this, her influence over army affairs gradually diminished, while simultaneously, her power over the conduct and administration of civilian hospitals continued to grow.

The army data had, Farr believed, provided him with clear proof that the London voluntary hospitals were much less effective than their provincial counterparts. The London hospitals had long claimed that their higher mortality rates were simply a result of the fact that their patients were drawn from the relatively less healthy citizens of the Metropolis. Farr's analysis of the army data appeared to deny this hypothesis, since the troops had been allocated to the war hospitals at random, their origin could have had no effect on hospital performance. Yet clearly, hospital mortality rates had varied enormously. The obvious conclusion to be drawn was that the major factor determining a patient's chance of survival lay in the choice of hospital, rather than their origin. The solution to the problem of high mortality in London hospitals, therefore, was not to be found in the pursuit of medical science, but in the imposition of a strict sanitary regime. Armed with this knowledge Farr and the increasingly zealous Nightingale[12] began to formulate

[12] Nightingale's relationship with Chadwick was becoming increasingly strong and she appears

a strategy that would force sanitary reform on the London hospitals initially, and subsequently upon any recalcitrant provincial hospitals that had failed to adopt the appropriate measures.

The strategy had two basic elements: to persuade, cajole and if necessary browbeat the hospitals into providing the information necessary to conduct a thorough analysis of their activities and then, publish the analysis, in order to increase the public and political pressure upon hospitals to make the necessary reforms. Nightingale began immediately, with the delivery of two papers to the National Association for the Promotion of Social Science, or Social Science Association (SSA) as it was more commonly known, which were subsequently published as the first edition of *Notes on Hospitals* (Nightingale, 1859). Although focusing largely upon hospital design and construction the book set the scene for what was to come later by observing that 'accurate hospital statistics are much more rare than is generally imagined' (1859, p7). This was followed up with the enormously influential *Notes on Nursing*[13] (1860) which was something of a polemic against the value of 'scientific' hospital medicine. The book emphasised the importance of hygiene in the treatment of disease and downplayed the role of the doctor in 'curing' the patient. The best kind of nursing, Nightingale argued, should be defined as 'the proper use of fresh air, light, warmth, cleanliness, quiet, and the proper selection and administration of diet - all at the least expensive of vital power to the patient'

to have been influenced by his sanitary conviction (Widerquist, 1997)

[13] The book had sold fifteen thousand copies within two months of publication.

(p7). While Nightingale suggested the need for statistical analysis and, simultaneously, insinuated the expected outcome of that analysis, Farr was supporting the re-establishment of the Statistical Society's committee on hospital statistics.

At its first formal meeting in June 1861[14], the committee considered that it was 'of the utmost importance that the metropolitan hospitals should adopt one uniform system of registration of patients' (JSSL, 1862, p 384, Resolution 1). Developing this, they described the form that the system should take, adding that 'the nomenclature employed by the Registrar-General [should] be adopted, with the additions contained in the forms submitted by Miss Nightingale to the International Statistical Congress' (Resolution 4, p385). Alluding to the difficulty of acquiring the necessary statistics, the committee resolved that each hospital should also have an officer, dedicated to the task of attending to the registration of patients. In complying with these recommendations the hospitals would be reguarly supplying uniform data, based upon the nosology devised by Farr for the General Register Office (GRO) that would allow comparisons to be made not only with other hospitals, but also more generally across the population.

These statistics were to be gathered annually and made public through two main mechanisms. Firstly, the Council of the Statistical Society had 'kindly undertaken to publish in their *Journal* some of the leading statistics of the metropolitan hospitals' (JSSL, 1862, Resolution 5, p385) provided that the authorities of the hospitals

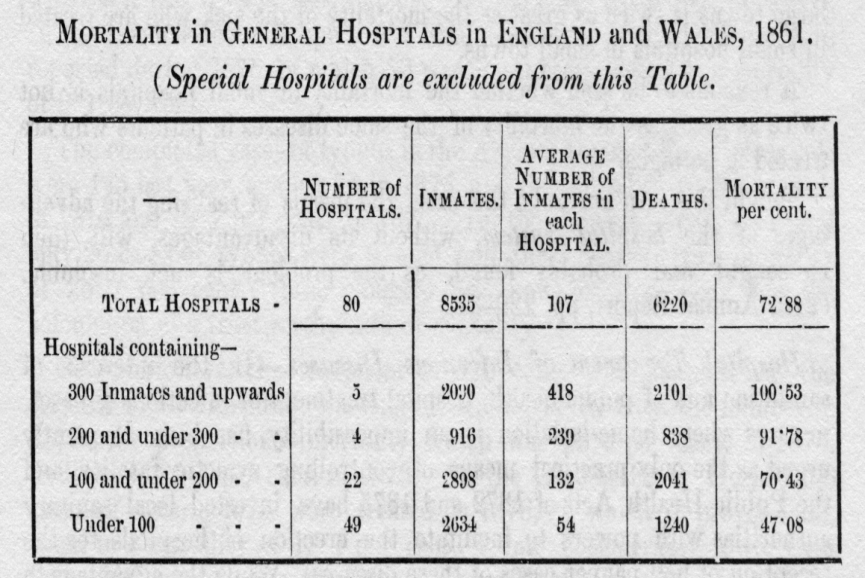
[14] The full text of the resolutions that were passed by the committee is included in Appendix A.

supplied the Society with the necessary summary of the statistics for the year; 'such summary to comprise the data tabulated in the manner represented on the accompanying form' (p385). Secondly, the Society suggested to the authorities of the hospitals that it would be of 'great public advantage if they will also publish annually a full report of the statistics of disease treated within the hospital' (Resolution 6, p385). This annual report of the hospitals' activities was also to be compiled on the basis of the 'arrangement and nomenclature employed by the Registrar-General and by Miss Nightingale' (p385). Thus, the hospitals were to provide their statistics individually to their subscribers and contributors through the annual report, and collectively through the medium of the Statistical Society's Journal, to enable comparisons to be made and reforms to be applied where necessary.

The campaign gathered momentum in the early years of the 1860s. In the 24th annual report of the Registrar-General, Farr published a table demonstrating the higher mortality rates of the large voluntary hospitals (see Figure 4.5).

Farr's message here was unambiguous; the larger the hospital the higher the death rate. This was a direct attack upon the long established voluntary hospitals and upon their senior medical staff; the elite of the profession. While recognising the relative economy and efficiency of these large-scale institutions, Farr argued that:

> "One great evil has often counterbalanced all the advantages. The collection of a number of persons, exceeding those of an ordinary family, under one roof, has hitherto always had a tendency to increase the dangers of disease; ... and the patients are less likely to recover health in the sickly atmosphere of a large building in a city than in pure country air. ... It must be stated



MORTALITY in GENERAL HOSPITALS in ENGLAND and WALES, 1861.
(*Special Hospitals are excluded from this Table.*

—	NUMBER of HOSPITALS.	INMATES.	AVERAGE NUMBER of INMATES in each HOSPITAL.	DEATHS.	MORTALITY per cent.
TOTAL HOSPITALS -	80	8535	107	6220	72·88
Hospitals containing—					
300 Inmates and upwards	5	2090	418	2101	100·53
200 and under 300 - -	4	916	239	838	91·78
100 and under 200 - -	22	2898	132	2041	70·43
Under 100 - - -	49	2634	54	1240	47·08

Fig. 4.5: **Mortality in General Hospitals in England and Wales (Sourced from Farr, 1885)**

> scarcely anything could be worse than ventilation and all the arrangements of the old hospitals. ... the investigation of the effects of hospital air, and of treatment in the various establishments, requires great care and skill. It is so important, however, that it should be undertaken for the sake of the sick, and for the sake of medical science. ... A careful comparison of the duration and of the rate of mortality of certain well-defined diseases in hospitals and in private practice would settle the question." (24th Annual Report of the Registrar-General, 1863, p. 229-30).
>
> "It is evident from the preceding table that the mortality of the sick who are treated in the large general hospitals of large towns is twice as great as the mortality of the sick who are treated in small hospitals in small towns. ... It remains to be seen whether the mortality in small hospitals is not twice as great as the mortality of the same diseases in patients who are treated in cottages. ... Should this turn out to be the case, the means of realising the advantages of the *hospital system,* without its disadvantages, will then be sought and probably found, as the problem is not insoluble" (24th Annual Report of the Registrar-General, 1863, p. 231, original emphasis).

In these passages it is possible to discern an even more radical agenda. What Farr is implying, is that the safest and most efficient method of medical treatment is not to group patients together in a great centre of excellence, but rather to treat

them in cottage hospitals, or perhaps even their own homes. On this basis the large voluntary hospitals would no longer be required and the consultants who worked in them would be forced to gain and maintain their reputations in the medical marketplace, along with the rest of the general practitioners.

Nightingale also pressed home the attack with the publication in 1863 of the third edition of *Notes on Hospitals*. The book was critical of almost every aspect of hospitals and in particular the metropolitan hospitals. She observed that 'the various metropolitan hospitals have been erected, and their positions determined on no general system of medical or surgical relief for the metropolis, and without any foresight' (Nightingale, 1863, p.28). Lengthy discussions about the sanitary condition of hospitals and the defects of existing designs are followed by sections on principles of hospital construction and improved hospital designs that emphasise space, light, cleanliness and ventilation, but, the major addition to this book was the chapter on hospitals statistics.

'Hospital mortality statistics have hitherto given little information on the efficiency of the hospital, i.e., as to the extent to which it fulfils the purpose it was established for', she argued (p.5). If the uniform plan were to be adopted, it:

> "would enable us to ascertain how much of each year of life is wasted by illness,–what diseases and ages pressed most heavily on the resources of particular hospitals. For example, it was found that a very large proportion of the limited finances of one hospital was swallowed up by one preventable disease,–Rheumatism,–to the exclusion of many important cases or other diseases from the benefits of hospital treatment" (Nightingale, 1863, p.159).

The exact nature of the plan was laid out in great detail in the chapter. The

core of the system was a series of standard forms designed to record admissions and discharges (Appendix B), record each patient's disease according to the nosology designed by Farr for the GRO (Appendix C). Operations and attendant mortality from them were to be recorded on separate forms proposed by the International Statistical Congress (Appendixes D and E). This is the data that was to be submitted annually to the Statistical Society for analysis and publication, but in addition standard forms were produced for inclusion in hospital annual reports. The annual reports were to include four tabular statements detailing the annual activity with respect to In-Patients (Figure 4.6) as well as Out-Patients with a statement of the details of the nature of expenditure on each class of patients (Figure 4.7).

The following Annual Tabular Abstracts for the Yearly Report of the Hospital embody the other recommendations of the Congress :—

I. In-Patients.

Periods.	No. of Letters of Recommendation.*		Admissions.		Total Cases of Disease treated.†		Deaths.		Recoveries.		Otherwise discharged.		No. of Beds occupied.					
													Maximum.		Minimum.		Average.	
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.
1st Quarter . . .																		
2nd Quarter . . .																		
3rd Quarter . . .																		
4th Quarter . . .																		
Total for the Year .																		

* These columns are only required for Hospitals for which Letters of Recommendation are necessary.

† This column includes cases of disease occurring in patients *after* admission to Hospital.

Fig. 4.6: **In-Patients table for inclusion in the annual report**

Finally, there was a table to gather data on the sanitary statistics of the wards in which the patients were treated. This table described the physical dimensions of the

ward, the number and size of the windows, the number of beds, the space per bed, in terms of both area and volume, the number of fireplaces, the manner of ventilation and the number of water closets, baths and ablution basins. Also, hospitals were required to comment on the state of drainage and quality and quantity of the water supply (Figure 4.8).

2. Out-Patients.

Periods.	No. of Letters of Recommendation.*		No. of Patients.	
	Males.	Females.	Males.	Females.
1st Quarter				
2nd Quarter				
3rd Quarter				
4th Quarter				
Total for the Year .				

* These columns are only required for Hospitals for which Letters of Recommendation are necessary.

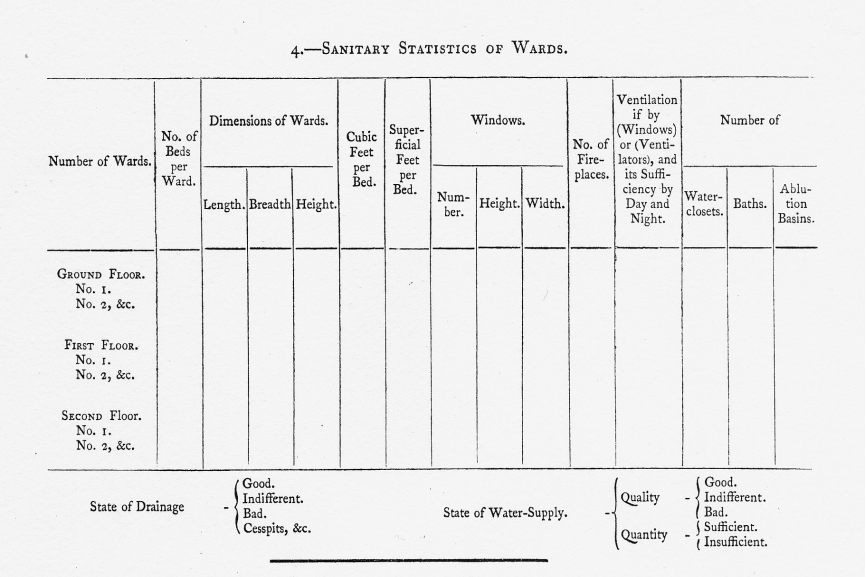
3. Cost of each Patient.

——	Food, &c., Wine, Spirits, Malt Liquor.	Officers and Nurses.	Drugs, &c. Instruments.	Other Expenses.			Total.
				Washing.	Firing and Lighting.	Sundries.	
In-Patients . . .							
Out-Patients . . .							

Fig. 4.7: **Out-Patient and Cost of Patients tables for inclusion in the annual report**

Overall, the collection of this data would provide a range of information about the activities and performance of the voluntary hospitals. 'The primary object of these tables' stated Nightingale 'is to obtain an uniform record facts from which to deduce statistical results' (Nightingale, 1863, p162). The kind of results sought were non-comprehensively listed as:

> 1. The total *sick population*—i. e., the number of beds constantly occupied during the year by each disease for each age and sex.
> 2. The *number of cases* of each age, sex, and disease submitted to (medical



4.—Sanitary Statistics of Wards.

Number of Wards.	No. of Beds per Ward.	Dimensions of Wards.			Cubic Feet per Bed.	Superficial Feet per Bed.	Windows.			No. of Fireplaces.	Ventilation if by (Windows) or (Ventilators), and its Sufficiency by Day and Night.	Number of		
		Length.	Breadth	Height.			Number.	Height.	Width.			Water-closets.	Baths.	Ablution Basins.
Ground Floor. No. 1. No. 2, &c.														
First Floor. No. 1. No. 2, &c.														
Second Floor. No. 1. No. 2, &c.														

State of Drainage - { Good. Indifferent. Bad. Cesspits, &c.

State of Water-Supply. - { Quality - { Good. Indifferent. Bad. Quantity - { Sufficient. Insufficient.

Fig. 4.8: **Table showing sanitary statistics of wards for inclusion in annual report**

or surgical) treatment during the year.
3. The *average duration* in days and parts of a day of each disease for each sex and age.
4. The *mortality* from each disease for each sex and age.
5. The annual proportion of *recoveries* to beds occupied and to cases treated for each age, sex, and disease.
(Nightingale, 1863, p162, original emphasis)

Nor, was the reader left in any doubt as to what use the statistics would be applied:

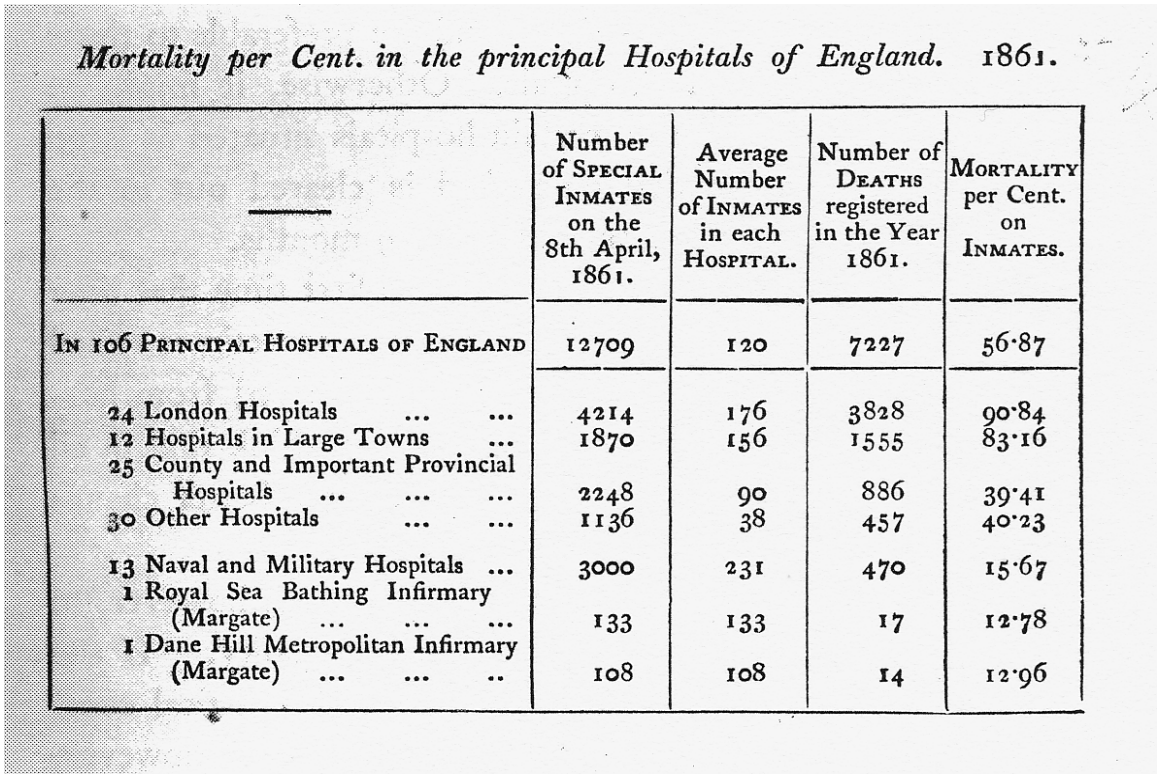
> "With fixed data, arrived at on these principles, we can readily obtain the proportionate mortality, not only of the whole hospital, but of every ward of it ... It need hardly be pointed out of what great practical value these and similar results would become, if obtained over a large number of hospitals ... As regards their sanitary condition, hospitals might be compared with hospitals and wards with wards" (1863, p163).

With the necessary statistics at their disposal, the reformers could claim that it was no longer doctors who were the arbiters of good medical practice. Solid

statistical analysis, based upon a uniform system of record keeping would provide irrefutable data that even the profession could not deny. But, unfortunately, for the success of the venture, Farr and Nightingale had revealed their underlying purpose too soon. Farr's questioning of the effectiveness and desirability of the large general hospitals in the *24th Annual Report* was matched by similar invective from Nightingale in the third edition of *Notes on Hospitals*.

Early in the book, Nightingale had included a table showing the mortality of the principal hospitals of England (Figure 4.9). This table shows the mortality percent of inmates as 39.41% for county and important provincial hospitals, 83.16% for hospitals in large towns and 90.84% for the twenty four London hospitals. This was another table of Farr's from the *24th Annual Report* which demonstrated that large hospitals had a higher mortality rate than small. It further demonstrated that it was the large London hospitals that were the most dangerous of all. "It cannot be denied" she explained "that the most unhealthy hospitals are those situated within the vast circuit of the metropolis" (1863, p4). Thus, she reveals the target of her attack: namely, the large voluntary hospitals and in particular those in London.

Like Farr, Nightingale openly questioned the need for the large hospitals. "In all hospitals, even those which are best conducted, there is a great and unnecessary waste of life ;" she railed "and ... as a general rule, the poor would recover better in their own miserable dwellings" (1863, p175). Hammering home the need for a uniform system of reporting by the hospitals, and complaining about her



Mortality per Cent. in the principal Hospitals of England. 1861.

	Number of Special Inmates on the 8th April, 1861.	Average Number of Inmates in each Hospital.	Number of Deaths registered in the Year 1861.	Mortality per Cent. on Inmates.
In 106 Principal Hospitals of England	12709	120	7227	56·87
24 London Hospitals	4214	176	3828	90·84
12 Hospitals in Large Towns ...	1870	156	1555	83·16
25 County and Important Provincial Hospitals	2248	90	886	39·41
30 Other Hospitals	1136	38	457	40·23
13 Naval and Military Hospitals ...	3000	231	470	15·67
1 Royal Sea Bathing Infirmary (Margate)	133	133	17	12·78
1 Dane Hill Metropolitan Infirmary (Margate)	108	108	14	12·96

Fig. 4.9: **Mortality of the principal hospitals of England**

inability to obtain 'hospital records fit for any purposes of comparison' (p176), she appealed to the philanthropists who supported the hospitals. The uniform system of hospital statistics 'would show subscribers how their money was being spent, what amount of good was really being done with it, or whether the money was not doing mischief rather than good' (p176). For the increasingly angry consultants of the metropolitan voluntary hospitals this was the straw that broke the camels back and they began to fight back vigorously.

4.5.1 The Ascendance of Medical Science

An 1864 reviewer of the third edition of *Notes on Hospitals* lamented that 'it is sad to see a work of so much value - full of such useful information - disfigured by a few serious and elementary mistakes' (MTG, 1864, p129). Carefully avoiding criticism of the extremely influential Nightingale the reviewer focused his attack upon the statistics prepared by Farr.

> "There is something audacious in the last column of this table, where twenty-four London Hospitals are credited with a mortality per cent on inmates of 90.84. No doubt it will be said this is the quotient of the figures employed; but we entirely deny their validity and accuracy of the impression thus conveyed" (p129).

This was the opening shot in an argument that was to become increasingly acrimonious. On the one side, Nightingale and Farr stubbornly defended their conclusions, on the other, the hospital consultants led by John Simon, the Medical Officer of Health, tore them apart.

Simon, a surgeon at St Thomas's hospital, had made his name initially in pathological research, gaining early fellowship of the Royal College of Surgeons as a result; then as political interests in London sought to resist the influence of Chadwick dominated General Board of Health, he was appointed Medical Officer of Health for the city. This position led to him being appointed Medical Officer for the General Board of Health after Chadwick's fall from grace in 1855. Simon, it has been argued, was a follower of the views of Samuel Taylor Coleridge in that he was opposed to democracy, Benthamite individualism, and laissez-faire (Stokes,

1989). These attitudes no doubt stood him in good stead in the reaction against Chadwick and, combined with his extensive family connections in the City he became a powerful figure in the British medical scene. Working in the tradition of his own early career, Simon used Board of Health funds to sponsor medical research and relentlessly appointed scientific medical men to his team, rather than the sanitation orientated people employed by Chadwick (Small, 1999).

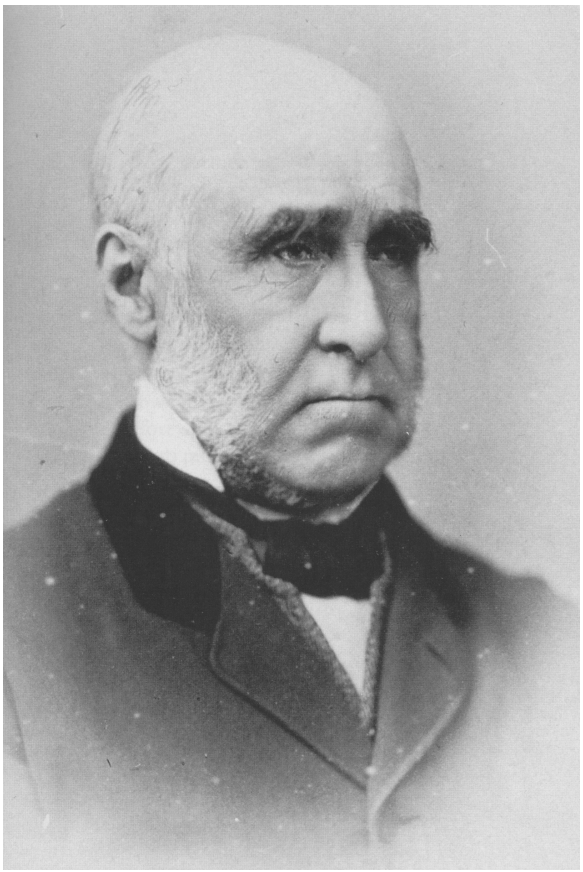


Fig. 4.10: **Dr. John Simon, medical officer of the General Board of Health**

By 1862 Simon was already at war with Florence Nightingale. Due to the continuing encroachment of the London Bridge Railway Station, St Thomas Hospital was seeking to relocate. Nightingale was arguing that the hospital should be moved

to a suburban site where the fresh air and good ventilation would surely improve the health of the patients. Simon and the other consultants of the hospital were utterly opposed to this move, because of the damage that it would do to their private practices. Arguing that they would be unable to provide emergency support to the hospital if it was relocated, Simon and his colleagues managed to defeat the sanitarians and have their new hospital built on the banks of the Thames, opposite the Houses of Parliament (Rivett, 1986, pp. 95-101).

The prominence of this issue had, by the time of the publication of the third edition of *Notes on Hospitals*, already polarised the debate, between the sanitarians and the hospital consultants. After the publication, a furious row ensued in the medical press between Farr and two consultants that were viewed by Nightingale as Simon's henchmen (Eyler, 1979, p184). These men, J. S. Bristowe of St Thomas's and T. Holmes of St George's, conducted a campaign in *The Lancet* and the *Medical Times and Gazette* (MTG) focusing almost entirely upon Farr's method of calculation of mortality[15].

In preparing his mortality statistics, Farr had always used the number of deaths in a period, usually a year, as the numerator and mean number of patients in the hospital as the denominator. This may seem counterintuitive as we would expect the number of patients treated in hospital over the course of the year as a more obvious denominator, but to Farr it made perfect sense[16]. Viewing the space inside

[15] The debate appears in *Lancet*, 1864, i, pp338-9, 365-6, 420-2, 451-2, 452, 469 and *Medical Times and Gazette*, 1864, pp211, 242-3, 264-5, 296-7, 405, 491-2.

[16] Not necessarily an abuse of statistics as Woodward states (Woodward, 1974, p.124).

the hospital as the object of investigation, he posited that the important measure is the amount of life at risk. Assuming that as one bed became vacant another patient would occupy it, what he was measuring was the exposure of the patients to the conditions of the hospital. Thus the only sensible denominator was the amount of life at risk, i.e. the average number of patients. From an alternative perspective, this measure seemed entirely inappropriate:

> "If, out of a fixed population of 10,000 persons, 200 die in the course of a year, the mortality will be at the rate of 2 per cent. But, if, during this supposed year, these same 10,000 persons had been successively inmates of an institution with 2,000 beds and the 200 deaths had happened within the walls of this institution, the result would have been for the institution a death-rate of 10 per cent. And again, if these same 10,000 persons had been on similar conditions inmates of an institution with 1,000 beds, or of one with 500 beds, the mortality of these institutions would have become respectively 20 per cent and 40 per cent" (Bristowe, 1864a, p.491).

The point Bristowe was making is clear; that by calculating rates of mortality on this basis, the magnitude of the number arrived at is entirely dependent upon the size of the institution being calculated[17]. That, he claimed, made the statistics entirely unreliable and went on to imply that their calculation was not a matter of honest scientific inquiry, but rather, an act in support of an unacceptable and inaccurate dogma:

> "If Dr. Farr had made his calculations about Hospitals in a tentative spirit, with the object of ascertaining whether they were likely to lead to any useful results, he would have acted in a way to which no exception could have been taken; if, when he had obtained his results, he had published them,

[17] Of course Bristowe fails to reflect upon the fact that the number of patients treated by a hospital is also likely to vary with the size of the institution. If we follow his argument to its logical conclusion, then the smallest hospitals should attract the highest percentage mortality rates; the reverse of the conclusion arrived at in Farr's tables.

> and had at the same time pointed out clearly all their imperfections, and that, even had they been perfect they would still have afforded no test at all of the relative healthiness of Hospitals, but possibly some test of the relative severity of cases admitted into Hospitals, his labours might have been regarded as trivial, but no complaint could have been made; but when both he, and Miss Nightingale under his guidance, not only publish such results, but themselves draw from them the inference, and try to mislead others into the belief, that the unhealthiness of Hospitals is in proportion to Dr. Farr's death-rates of Hospitals, we are bound to protest against the whole matter as an unfounded and mischievous delusion" (Bristowe, 1864b, p.492).

Simon had appointed Bristowe and Holmes to produce a major report on British and continental hospitals. Their conclusion was predictable:

> "The general death-rates of hospitals afford no test of the relative salubrity of hospitals. The condition of the hospital death-rate is determined almost exclusively by the character of the cases admitted, and by the rules or the practices which regulate their discharge" (Bristowe, 1864b, p.492).

Having set Bristowe and Holmes up as an alternative authority on hospitals, Simon was able to use the report, even before its publication, to influence political opinion behind the scenes and discredit Farr and Nightingale's work (Eyler, 1979, p.185). Arguing that no real progress could be made in reducing hospital mortality until such times as the causes of that mortality were fully and scientifically established, Simon proposed greater emphasis on and investment in medical research[18]. Once again, Simon's political acuity prevailed and Nightingale's influence failed as the political consensus swung behind scientific medical research, rather than engineering-based sanitary reform (Eyler, 1979, p.187).

[18] At this time discoveries such as Pastuer's work on the germ theory of infection, and John Snow's discovery of the medium of transmission of cholera, were emerging, which indicated that the causes of disease may indeed be pinpointed.

Nightingale and Farr did not abandon their attempts to promote a uniform system of hospital statistics at this point. Without the consensus of public and political opinion to promote compliance with the scheme, however, it was almost certainly doomed to failure. By 1864 the report in the *Journal of the Statistical Society* was complaining that 'the information embodied in the following tables is not complete' having failed to receive returns from a number of hospitals (JSSL, 1864, p. 401). Additionally they had received a letter from St Thomas's pointing out that as a result of the relocation the average number of patients in the hospital over the year was lower than normal, therefore they had refrained from furnishing these statistics. The following year, the situation had worsened considerably (JSSL, 1865, p527) and by 1866 they conceded that 'co-operation is becoming year-by-year less complete' (JSSL, 1866, p. 112). But, the impetus from the reformers may also have been waning by this time.

By 1866, Farr was showing a growing acceptance of the germ theory of infection (Eyler, 1979, pp187-9) and Nightingale, often supposed to have rejected the theory until her death in 1910 (Rosenberg, 1979), may also have been beginning to accept it (Small, 1999, pp.154-62). If this was the case then they were faced with pursuing their objectives on the basis of a theory in which they no longer believed, or simply abandoning the attempt. In any case it seems unlikely that their opinions were changed overnight and the criticism of hospitals was not based on a miasmatic theory of infection alone. Yet, despite continued attempts at persuasion and the repeated republication of their resolutions by the Committee on

Hospital Statistics, the attempt to govern the voluntary hospitals, in particular the metropolitan hospitals, through the promotion of a system of uniform statistical reporting appeared to have failed.

4.6 Summary and Conclusion

By the middle of the 19th-century, the character of the voluntary hospitals was changing. The increasing cohesion of medicine as a profession and medical advances achieved through the increasing use of hospitals as centres for teaching and research served only to increase the respect and status of hospital consultants and the institutions in which they worked. But as the number of teaching hospitals multiplied and the number of graduates from their schools increased, it became increasingly difficult for those who had invested considerable sums into medical education to access those lucrative hospital appointments.

In the rumblings of professional discontent doctors began to break down the mystique surrounding hospitals with their criticisms, aided greatly by radical journals such as *The Lancet*. William Farr, recognising that the arrangement of hospitals as independent and entirely autonomous institutions was neither effective nor desirable attempted to produce comparative statistics to demonstrate this. However, lacking the political and social connections he was unable to persuade the hospitals to make a sustained effort in this regard.

His meeting with Florence Nightingale gave him access to her powerful connec-

tions. Having established the cause of the horrific mortality in the Crimea and convincing Nightingale that, on the basis of a miasmatic theory of infection, sanitary reform was the only answer, they began to campaign for radical reform of the hospital system. The centrepiece of this campaign was a uniform system of hospital statistics that was designed to collect comparable data from the hospitals, thus allowing an analysis that would reveal which hospitals were responsible for excessive mortality. But, without any significant levers of power, their scheme was dependent upon co-operation from the hospitals, the very hospitals that they were trying to control and, as they ultimately revealed, abolish.

With this revelation, it was inevitable that the potential losers, i.e. the hospital consultants would try and discredit the attempt. Under the leadership of John Simon consultants attacked both the statistics and the basis upon which they were prepared. Positing that the miasmatic theory of infection was unreliable and that unrestrained sanitary reform would do nothing to demonstrate the causes of infection, they argued instead, that effort should be directed towards scientifically establishing the true cause of infection. Only then, could the most appropriate measures take place to minimise the potential danger. Through the extensive political influence of John Simon, the scientific medical solution triumphed over the engineering led solution.

Nevertheless, the potential had been shown, that through the collection of uniform and comparable data from the hospitals, influence could be exerted over their

activities. Arguably, if Chadwick had remained President of the General Board of Health, sanitary reform would have remained at the top of the political agenda and the system devised by Farr and Nightingale may have survived long enough for them to establish, through the Statistical Society, authority over the activities of the hospitals. Such an outcome would be more than a simple re-establishment of accountability, rather, with the ability to make the activities of one hospital not only visible, but also comparable to the activities of similar institutions, it would have allowed the establishment of norms of acceptability and the authority to exercise government over deviation from those norms.

What has been established in this chapter is that there was a recognition amongst some victorian reformers that the reporting practices of the hospitals were a potentially powerful mechanism for capturing information about their activities which could be used to comment upon and potentially influence those activities. The surveillant power of the reports to identify deviation from norms was becoming clear, but the ability of reformers to make the hospitals to provide the specific information that they needed was, so far, quite limited. In the case of Farr and Nightingale they had sought to base the system on a medical nosology and it was this factor that was central to the failure of their system. The language at its heart was generally recognised to be medical language and that was established as the domain of the clinician rather than the lay person. Without formal medical qualifications Farr and Nightingale could not effectively challenge medical interpretations of reports or challenge medical practice. The basic structure of reporting through

a uniform system may have been a good idea, but its fulfillment would require another approach that avoided the conflict with medical expertise. The next chapter will show how this approach began to emerge.

5. THE UNIFORM SYSTEM OF HOSPITAL ACCOUNTS: A MECHANISM FOR CONTROLLING REFORM

5.1 Introduction

The failure of William Farr and Florence Nightingale to either persuade or coerce the voluntary hospitals to adopt their system of uniform hospital statistics was undoubtedly a setback for those seeking reform of hospital practice and development. Despite the failure there was a growing body of people who, for various reasons, sought to press ahead with reform[1]. Further, the utilitarian perception that collection of data in a uniform fashion would provide the evidence necessary to achieve the most efficient methods of managing the hospitals prevailed amongst these individuals (Rivett, 1986: Waddington, 1995, 2000). The linking of the uniform system of hospital statistics to those known to subscribe to an increasingly discredited miasmatic theory of infection meant that the possibility of pursuing that method of data collection for the purpose of exerting influence over those involved in the hospitals was unlikely to be pursued. Instead, it will be shown that

[1] The question of hospital reform was high on the agendas of reform organisations such as the Charity Organisation Society and the National Association for the Promotion of Social Science in the second half of the 19th century.

the attention of reformers turned from data centred on the failure of hospitals, and by extension those doctors who worked in them, to keep people alive, towards data that revealed the financial effectiveness of their activities and (by extension) the cost effectiveness of those institutions at treating the poor. This approach was beyond the realm of medical expertise and provided an economic framework that potentially allowed a challenge to be made to the practice of hospital management.

The fundamental problem remained for the reformers that they had no authority to command the hospitals to adopt their preferred uniform system of accounts[2]. To counter this problem reformers devised an ambitious scheme, known as the Metropolitan Hospital Sunday Fund (henceforth referred to as the Sunday Fund), to promote adoption of the system amongst the London hospitals where the problems were deemed to be worst. The Sunday Fund was at least partially successful in its aim of promoting the adoption of uniform accounts. However, adoption may have had as much to do with a growing concern within many of the hospitals and amongst nearly all of the general practitioners that the continuing expansion of hospital numbers was damaging to the reputations and livelihoods of all concerned.

This chapter will analyse the uniform system of accounts and those events that led to their adoption by hospitals in response to the demands of the Sunday Fund. This will proceed with a review of the extant literature of uniformity in accounting

[2] The concept of uniform hospital accounts appears to have been devised by Henry Burdett with two of his colleagues at Queens Hospital, Birmingham in 1869. The exact form of their system has been impossible to discover, but the motives espoused by Burdett hardly changed over the decades that he was involved in hospital management, so it is not unlikely that the accounts devised at Queen's were similar to those later published by Burdett.

in order to establish the acknowledged, but largely unexplored possibilities of these systems as technologies capable of centralizing power and thus, creating the ability to govern those who are the subjects of the system. Burdett's system of accounts will then be examined before an exploration of the creation of the Sunday Fund and the circumstances that supported accession to the Fund's desire for the adoption of the accounting system by many of the London hospitals. The final section will assess the success of the Sunday Fund at achieving significant influence over the hospitals.

5.2 Uniformity in accounting systems

The historical existence of uniform accounting systems has been recently largely ignored by the academic accounting community, with the main exception of the case recently brought to the fore by Walker and Mitchell. Their studies explored the attempt made by the British Federation of Master Printers (BFMP) 'to propagate the universal adoption of a uniform costing system as a solution (through its impact on tendering and pricing) to the problem of excessive price competition' (Walker and Mitchell 1996, p.99). The papers published by the authors on this case ranged from analysis of the efforts of the BFMP in their socio-economic context (Walker and Mitchell, 1996) through an examination of the contingencies that were influential in the initiation and subsequent problems of the development of the scheme (Mitchell and Walker, 1997) to an exploration of the reactions of the employees

of the firms concerned, through the activities of their trade associations (Walker and Mitchell, 1998). This case was clearly multifaceted and complex, leading the authors to concede that a number of different theoretical perspectives were useful in illuminating different aspects of the case.

One aspect of the case that is particularly relevant to this study is the way in which the efforts to establish the uniform costing system by the BFMP, (an organisation external to, although affiliated with, the manufacturing firms concerned), was viewed either as a process of 'informal cartelization' (Mitchell and Walker 1997), or alternatively as the creation of a 'supranational organization' designed to monitor the activities of its member firms (Walker and Mitchell 1996). The creation of this organisation facilitated the central gathering and collation of information on those firms that were its subjects. Additionally, this supranational organisation appeared, to some extent, able to discipline those companies who resisted the implementation of the costing system. In some respects, this kind of activity defies our understanding of costing as a practice internal to the organisation, whatever our theoretical understanding of its nature and function. It may be reasonable to argue, therefore, that it is the uniformity aspect of this system which has taken it outside the organisation, enabling the attempts to implement it nationally across the sector. Thus, uniformity in accounting can be perceived as implicated in the attempts by specific groups to influence significant sections of a sector, or even entire sectors of industry or society.

That systems such as the one outlined by Walker and Mitchell were widespread and enduring, can be demonstrated by the historic academic interest that was displayed in them, whether they are defined as uniformity (Solomons, 1950a,b: Most, 1961), or simply as attempts to standardise within an industry (Vent and Milne, 1989). As to the origins of these uniform costing schemes, the details are sketchy. Solomons and Most list a bewildering array of schemes across a range of industries, but suggest that while the National Association of Stove Manufacturers had initiated a scheme by 1891 in the US (Solomons 1984, p.239), the earliest such scheme in Britain was that set up by the Printers Federation in 1913. To date most of the academic work on uniformity has focused on these uniform costing systems, however, uniformity in accounting was not restricted only to costing, but often to more general schemes. Efforts to implement general schemes, like the one under study here, pre-date the costing schemes considerably and were raised in the context of railways (King, 1849: Scrivenor, 1849, 1851) and government accounting (Preston, 1840)as well as the hospitals and poor law.

Ultimately perhaps, uniformity in accounting should be credited to Jeremy Bentham and his brother Samuel, because 'for the Benthams, particularly for Jeremy, it was apparently a near fetishistic obsession that accounts be uniform - where necessary implying centralised regulation by the state'[3] (Gallhofer and Haslam, 1994b, p.247). Thus, the costing schemes may simply have exhibited only partially some

[3] For more details on the Benthams and accounting see also: Goldberg, 1957, Hume, 1970, Gallhofer and Haslam, 1994b, 1996, 2000 .

aspects of the potential of uniform accounting systems, with greater capacity to centralise contained in the visibilities created by more general systems. A greater awareness of just how influential a uniform accounting system can become in an economy is best appreciated by looking at what was probably the largest and most successful implementation of uniform accounting known: that in use in the 20th century Soviet Union.

Until the Russian Revolution in 1917, the development of Russian accounting and the Russian accounting profession had in many ways paralleled and even been modelled on the profession in the United Kingdom (Bailey, 1992), but the post-revolutionary upheaval led to some radical changes in the way that accounting was conducted in Soviet Russia. In 1973 George Gorelik described the historical development of Soviet uniform accounting:

> "Since the October Revolution the tasks of accounting in the Soviet Union have changed ... Instead of serving narrow, private business interests, the double-entry capitalist accounting of the pre-revolutionary days was called upon to assist the new leaders in the development of the Soviet state capitalism. ... The centralised direction of the Soviet economy created the need for consistent and comparable data – for a uniform system of recordkeeping (*edinaya sistema uchata*). The result was a gradual development of three interrelated systems of recordkeeping which rely generally on the same primary data." (Gorelik, 1973, pp.137-8)

Gorelik identified the three primary elements of the record keeping systems as operational-technical record keeping, statistical record keeping and accounting, which together formed a pervasive and insidious system that, he argued, had grown in scale and influence right up to the time of his paper. While he broadly identified the uniform accounting system with the success of the Soviet regime's rapid

programme of industrialisation, by the 1960s and 70s the system was, Gorelik suggested, implicated in the creeping paralysis of the Soviet economy. This he regarded as a technical failure of the ability of the system to respond to changing economic conditions. Yet, it seems strange (and patronising) to imply that Russian planners and accountants were somehow incapable of developing the system, or devising a new system which would better serve the interests of the country. An alternative explanation might be that, despite any apparent degradation of its effectiveness as an economic tool, the Soviet uniform accounting system had an alternative function, as a technology of social and organisational control, a function which, arguably, in the 1970s it was still serving quite well.

Despite the reliance of Gorelik's analysis of the success of uniform accounting according to its ability to provide information for economic decision-making he does concede that 'without a uniform system of recordkeeping, management of the Soviet command economy from the centre (Moscow) would have been very difficult' (p.148). Here again there is evidence of this constitutive aspect of uniform accounting, in the way that it aids and abets the construction of centralising social structures that in this case can influence and direct, not only groups or sectors within Society, but an entire nation. In this respect it could be argued that the Soviet accounting system mirrored the aims, albeit more modest in scope and scale, that Nightingale and Farr had for their system of uniform hospital statistics, with their apparent intention to gather data that would allow them to influence hospital practice and development. Thus, we can view uniform accounting as one of a

parallel set of technologies (along with statistical and operational-technical data in the Soviet case), employed to bring organisation and control into areas where previously there had been none. In fact, the exploration of uniform accounting as a possible mechanism of control was already being initiated even as Farr and Nightingale were struggling in vain to gain acceptance for their statistical system.

5.3 The Uniform Accounting System of Henry Burdett

The system of accounts that was adopted by the Sunday Fund was devised in 1869 by Henry Burdett (later Sir Henry Burdett) during his time as administrator of the Queen's Hospital in Birmingham[4]. It has been stated that he was assisted in this task by two of his colleagues, but their names appear to be unknown and the records of Queen's from this time have not survived. It seems likely, however that Burdett was the driving force behind this effort. He had the technical expertise and, the prolific activities of his long life show his apparently boundless energy and appetite for work[5]. The early version of the uniform accounting system was not published; it first appearing in print in 1893 (Burdett, 1893). It is therefore difficult to establish how much, in form and function, the system changed from the moment of its creation to its initial publication (it is easier to establish the changes in the later revisions which were also published). The system was very detailed

[4] Burdett wasn't a professional accountant, but he had conducted his early training in a bank before moving to the Queen's Hospital.

[5] As well as establishing himself on the board of the Seaman's hospital at Greenwich, Burdett was the author of a number of books and periodicals on hospital practice, including an Annual publication on the voluntary institutions, as well as later being the founder and editor of a weekly journal called 'The Hospital'.

and ran (in 1893) to a volume of some 76 pages that laid down a comprehensive set of prescriptive guidelines for hospital accounting and management, the main focus was on general economy with special regard to procurement, alongside a consideration of medical economy and discussions of how to prevent fraud.

Burdett, no doubt aware of the difficulty of persuading suspicious and recalcitrant hospital managers and secretaries to adopt his system, was keen to demonstrate that it was not merely an abstract construct of his own mind, but rather was based on a great deal of external research and experience of hospital practice:

> "during the last twenty five years we have made a large demand upon the patience, kindness and consideration of the officers of the various hospitals and institutions in the United Kingdom, British India, the Colonies and the United States of America. Often we have had to trouble them with enquiries, and ask them to fill in various forms, frequently involving the sacrifice of much time, and the exercise of no little patience and care." (Burdett, 1893, p.5)

Pursuing this theme, Burdett observed that the index of classifications used had been 'adopted by a general meeting of [Hospital] Secretaries' (Burdett, 1893, p.7). Cajoling aimed directly at hospital officials suggested that much of the time that they spent responding to queries about the management of the institution could have been avoided 'had the accounts of the institutions been kept on something like an identical plan' (Burdett, 1893, p.6). He further legitimised the scheme by observing that 'there is nothing particularly novel in the plan-which is simplicity itself-seeing that manufacturers and the heads of large business houses have been compelled to keep their accounts on some similar system for years past' (Burdett,

1893, p.8). By adoption of the uniform accounts, he explained, the affairs of charitable institutions could be favourably compared with the best business practices throughout the world.

The ease of use of the system could not be overstated. In response to a 'general desire for the publication of a set of books and forms of account which can be readily obtained by those institutions that decide to adopt the uniform system' (Burdett, 1893, p.7) the Scientific Press[6] had been commissioned to publish just such a set of books and forms of account. Reference was made to features of these books and forms that promoted facility and accuracy in the keeping of the accounts. For instance, each of the various analysis books carried a totals column in addition to the normal analysis columns. This was done in order that:

> "when each of the columns is cast up, the totals at the bottom of each page, when added together, will be identical with that of the total column ; and so it will be easy to check the castings, and prevent the carrying forward of mistakes from one page to another." (Burdett, 1893, p.17)

A complete listing of the component parts of the system was given as: 'a Cash Book; a Cash Analysis and Receipt Book; a Subscriber's Register; an Alphabetical Book for Donations; a Legacy Book; an Invested Property and Rent Book; an Analysis Journal; a Monthly Journal; a Ledger; a Wages Book and Petty Cash Books' (Burdett, 1893, p.10). By use of these books, he argued, the institution could maintain a perfect record of its activities, but this record would avail them little in the prevention of fraud if they did not include a duly audited statement of accounts

[6] Burdett was the owner of the Scientific Press

in the annual report. That in turn must correspond exactly to other items in the report, such as the demonstration of funds raised in the lists of contributors[7]. This was not seen as a panacea, however, as 'an audit by a firm of public accountants alone is neither sufficient nor satisfactory' (Burdett, 1893, p.41). It was crucially important, he argued, that an active member of the board of management should be involved in the audit and should ensure that the published statements were arranged so that nothing was either suppressed or hidden. Observing that experience had shown that the commonest frauds were typified by a failure to publish the 'true facts' in the report he stated forcefully that 'the figures in every account published should agree with the amounts given in detail in the Annual Report, and the public are justified in viewing with suspicion every institution where this practice is not duly adhered to' (Burdett, 1893, p.10). By involving a member of the management team Burdett was essentially insisting that one individual took responsibility for the veracity of hospital accounts as published in the annual report and, given the likely shame and disgrace that would arise for the individual concerned, should the accounts turn out to be false, it seems likely that this would be a highly effective measure. Using such arguments, Burdett, and the Metropolitan Hospital Sunday Fund, which was using at least part of his system, were attempting to assert the authority of the annual report as the primary document, capable of providing accurate information upon which to base judgments about the comparative efficiency of

[7] There is an implicit assumption here that the lists of contributors would normally be correct. This is probably reasonable, as the vast majority of contributors would, most likely, check the report to see that the extent of their philanthropy had been correctly recorded.

the institutions concerned. While often careful to avoid offending the sensibilities of the managers and employees Burdett was equally capable of clearer statements of intent:

> "our object in publishing this system of books and accounts is to bring ascertained and accurate facts to the knowledge of those engaged in hospital administration, with the view of exciting an interest in the many questions which will necessarily arise when uniformity is secured. Everybody who has any knowledge of hospital work is aware of the great differences which exist . . . in the details connected with the management of institutions under the voluntary system." (Burdett, 1893, pp.8-9)

Thus, through the production of uniform and comparable information, the managers and administrators of the voluntary hospitals were expected to examine significant differences that existed between the operations of their own institution and others. Yet, the uniform accounting system was detailed and complex and was designed to do far more than merely stimulate a management response to areas of concern.

5.3.1 Rendering Calculable the Economy of the Hospital

Much of the discussion in Burdett's accounting system considers the minutiae of the day-to-day running of the hospital, providing detailed procedures and pro forma statements to enable the carrying out of normal activities in a standard fashion. The procedures considered extended into all areas, from the lowest functions of procurement, through the acquisition of funds, to the execution of medical duties.

The principal features were as follows. The subscriber's register was designed so that when an individual's name appeared in the register, the entry would stand

for nine years. Clearly, to be so entered in such a register meant that the individual concerned was likely to attract the attention of hospital collectors for most of the next decade. Additionally, the register made it clear to the secretary of the hospital the date on which the subscriber had initially paid. This offered the advantage of being able to reapply to the individual concerned for another subscription exactly twelve months after the previous subscription had been paid thus ensuring that the subscriber 'may not be annoyed by being applied to for payment irregularly, or at the date in the year when the payments have not been previously made' (Burdett, 1893, p.17). Perhaps more importantly the register enabled the secretary 'to see at a glance if any, and which, subscriptions are in arrear' (Burdett, 1893, p.17). The register also ensured that those who did not subscribe, but gave occasional donations could be identified and applied to on a regular basis for further contributions[8].

Burdett had much to say on the internal economy of the hospital. In particular, a lengthy chapter was dedicated to the investigation and supervision of contracts for food and fuel. The differing cost of these provisions was one of the most significant reasons for highly divergent hospital costs. Burdett discussed at length the 'amazing' differences that could occur between the cost of an item at one hospital and the cost of what was supposedly the same item at another. An item like potatoes for example 'will cost one hundred percent more at one institution

[8] While Burdett's recommendations stopped well short of the kind of system employed at Edinburgh Royal Infirmary, (see chapter 3), the data collected in the register of subscribers would have been extremely useful in compiling the kind of data required to conduct an analysis in the Edinburgh style.

than it does at another' (Burdett, 1893, p.48). Similar differences, he argued, could be found in the prices of nearly every other item. Nor he explained, was a high price a guarantee of high-quality; a difficult area, he conceded, because, different institutions had different standards of quality. Yet, whatever the starting point for quality it was an acknowledged problem that suppliers tended, over time to provide increasingly inferior articles, with the result that 'grave and often well founded complaints are made by the patients as to the quality of the food supplied' (Burdett, 1893, p.47). The problem of procurement, therefore, was one which required a careful system with the appropriate checks and balances to ensure that contractors were appropriately chosen and held to their contract.

The first step to remedy this situation, he proposed, was to form a subcommittee of management to supervise the allocation and continuance of contracts. But this committee would be powerless to act against recalcitrant or defaulting contractors if the form of the contract were insufficient to the task. The contract, therefore:

> "is of the first importance. It should empower the institution or its representatives to reject every article of inferior quality, and to purchase, without impeding or lessening the force or validity of the contract, articles of proper quality in their place from any person they may think fit to select, the difference of price, if any, as well as all attending and incidental costs and expenses, being borne by the defaulting contractor. " (Burdett, 1893, pp.8-9)

This empowerment should also extend to an ability to terminate the contract should irregularities continue and, should enforce that each contractor should maintain full responsibility for the contract and not assign all or any part of it, to any other individual, without express permission of the management. The difficulty

with such an approach, was of course that any contract was open to legal challenge, but Burdett's system was equal to the task.

The uniform system included a standard form to be used in the tendering process. Each item of food or fuel, was completely specified in order that no dispute should arise. For instance, bread should be the 'best household, well and properly baked and cooled, unadulterated, and free from alum, in Loaves of 4 lbs. each' while coal should be 'best household coal, either Hartley's, Hetton's, Lambton's, Pelton's or Stewart's, thoroughly screened and free from small pieces, dust, or slate, and to produce the pit certificate for the same' (Burdett, 1893, p.63). Contractors were required to supply a price for each item on the list, then, when the tenders were opened the consumption figures for the last quarter were applied to ascertain the total cost of each tender for the quarter. Once the prices had been obtained, it only remained for the committee to award the contract to the individual supplying the best price, assuming that they had no unsatisfactory experiences with that individual in the past. Of course, by laying down such a detailed specification, Burdett was not only ensuring well specified and secure contracts, but was also defining the standard of food and, to a certain extent, the diet of every patient in every adopting hospital.

Patient diet was normally under the sway of medical personnel, but Burdett was prepared to go much further than simply defining the list of available provisions. Referring specifically to the London hospitals he observed that:

> "one great cause of relatively large expenditure of Metropolitan as compared

> with provincial hospitals arises from the system of having as resident medical officers men who have only just qualified. These young officers have, necessarily, had little or no administrative experience of training, and therefore are not alive to the best methods to adopt to secure and enforce economy when ordering medical comforts, extras, and appliances. . . . In the matters of dressings and bandages the extravagance is usually great, especially at Clinical hospitals, where the students, having no knowledge of the value and cost of these articles, very frequently waste a good deal of material which might and would be saved were the cases entirely and hands of a careful surgeon of trained nurse of experience." (Burdett, 1893, p.42)

Burdett placed the blame for this expense squarely on the shoulders of junior doctors. He explained that an inquiry had shown that a change in the personnel of the house surgeon or the house physician typically led to an increase of expenditure in the ward concerned of some £200 in the first year. This effect could be observed clearly in provincial hospitals, where junior appointments were made for between three and five years. In London however, the duration of the appointment of a junior doctor was only six months[9], thus placing the costs of the London hospitals under the constant sway of inexperienced and inefficient staff.

Deeming that these inefficiencies were confined not only to clinical treatment, but also extended into the prescribed dietary regime that inexperienced doctors were offering patients, Burdett suggested that a solution could be found in one of the 'Scotch hospitals, where thrift is a prominent feature of the administration' (Burdett, 1893, p.43). Specifically, he was referring to the Royal Infirmary of Edinburgh where 'the need for an alteration of the prevailing system in English

[9] This system existed as a result of the intense pressure for positions in the London hospitals. Doctors who could claim such experience were much more likely to attract wealthier and lucrative clientele. It was also entirely supported by the senior medical staff who typically charged large sums of money to confer a position.

hospitals is eloquently testified to by the results secured by the Board [of that institution]' (Burdett, 1893, p.44). The system was one in which books were kept that allowed the relative cost of treatment under each physician and surgeon to be brought out in a monthly return[10]. Costs were captured in monthly returns under three broad headings: consumption of wines, spirits, malt liquors and aerated waters; consumption of butcher meat and extra articles of diet; and the usage of surgical dressings in the treatment of cases under each surgeon (Burdett, 1893, pp.66-7). A separate column captured the mean number of occupied beds during the month and thereby allowed a calculation of consumption per bed as well as per ward. Burdett explains why this system would prove so effective in reducing expenditure:

> "Dr A., for instance, sees that his patients cost considerably more than Dr B.'s, and as a result, he goes down to the Infirmary when the monthly return is delivered, and, accompanied by the resident medical officer, he carefully revises the whole of the diets and list of extras, so as to secure that he shall not occupy in the succeeding month the invidious position of spending twice as much as any of his colleagues upon the cases which occupy beds allocated to himself . We have visited the Edinburgh Royal Infirmary, conferred with the superintendent, examined the system and its results, and have formed the conclusion that its general adoption would tend to bring down the expenditure in metropolitan and provincial hospitals to an extent which would largely remove the existing differences in the actual cost of each bed occupied in each of the principal British hospitals" (Burdett, 1893, p 45).

That this system was effective is not surprising. No doctor, especially one of junior rank, would want to have been thought wasteful of the hospitals resources

[10] This system had been instituted after a dispute between the managers of the ERI and Dr Joseph Lister over the cost of his new antiseptic treatment. Ultimately, Lister had won the argument, largely by dint of his impressive results, but the managers, conscious of the bad publicity that had arisen had decided to record the relative cost of the activities of the hospitals medical staff in order to defuse criticism that doctors were allowed a free reign.

even if only for purely selfish reasons. Anyone so identified would certainly have found it difficult to secure a more permanent position in that or any other hospital and only from such a position could a practitioner secure the most lucrative patients for his private practice. In any case it seems likely that it was, as Burdett stated, a shameful position to be in, attracting the opprobrium of senior colleagues and peers alike. In such an environment junior doctors might have striven to avoid such an outcome, to the great benefit of hospital finances and the possible detriment of patient care. This can be seen as a clear example of accounting stimulating a response on the psyche of the individuals under its gaze influencing their behaviour to minimise the cost of their activities, at least down to some sort of parity with that of their senior colleagues.

That his system of accounts had a power greater than previous mechanisms of control is supported by Burdett as he describes the failed attempts of committees of management to query the apparent extravagance of doctors, who invariably responded that the patients concerned were special cases, where the extraordinary expenditure was merited by the peculiarities, such as emergency, or severity, of the case. The lay managers, with no specialist medical knowledge, were of course in no position to contradict these assessments and merely had to accept them as true. Attempts to circumvent these problems by electing one or two doctors onto the committee of management invariably did little to help as ‘there is no profession where jealousies prevail to the same extent as they do in the medical, and each physician and surgeon has felt great delicacy in calling in question the work and

treatment of his colleagues' (Burdett, 1893, p.46). In light of these failures, Burdett posits that the Edinburgh system is 'the only one calculated to affect materially the expenditure of a great hospital' and therefore did 'strongly recommend its adoption by the committee of every institution which desires to be economically and properly administered' (Burdett, 1893, p.46).

This last piece of rhetoric is typical of the kind of phrasing that pervades Burdett's volume. Regularly the insinuation that those institutions that do not adopt his system are either incompetent, or intransigent, or possibly even corrupt appears on his pages[11]. Although he was always careful never to slur the voluntary ideal, preferring instead to exalt it as a 'noble system of helping others' (Burdett, 1893, p.8), it is not difficult to discern the underlying sense that some, perhaps many, of the hospitals were sites of great inefficiency and misuse of charitable funds. *The Uniform System of Accounts, Audit and Tenders* was a device intended to counter these problems. By ensuring a uniform preparation of accounts through its extensive classification system, by pressing that extensive data should be published in the annual report and that it in turn should conform to the strictures of the system, the *Uniform System* attempted to provide data that would reveal the excesses of maladministration and slack practice. Adoption of the system in full meant the application of techniques which were themselves designed to expose the malpractice

[11] He does in fact appear to have regarded some of the hospital boards as genuinely falling into one or other of these categories. St. Thomas' in London for instance, was for many years one of the main targets of his anger as a result of the perceived extravagance of its board. The new hospital building particularly attracted his venom when he observed that 'one of the pavilions [is] not intended for patients, but constitutes a palace ... for the treasurer' (Burdett, 1881, p.4).

to the malpracticers and to their peers and, by dint of the exposure and the associated shame, enforce upon them a change in their ways. It is equally understandable that many of the managers and other officials of the institutions concerned were reluctant to engage with such a system, but by 1893 when the *Uniform System* was first fully published the tide was already beginning to turn against the unwilling: it had been a different story when the first calls for adoption were made back in the 1860s. Equally, the world of hospitals looked rather different by 1893, than it had in the 1860s and nowhere was this more pronounced than in London.

5.4 Increasing Problems in the Voluntary Hospital Sector

The emergence of Burdett's system of uniform accounts occurred in a time of increasing problems in the British voluntary hospital sector. As Farr and Nightingale had sought a solution to the hospital problems that they perceived in the 1850s and early 1860s by means of uniform hospital statistics so, it will be shown, the reformers who took up their mantle throughout the last quarter of the century sought to find mechanisms to control hospital activity by means of uniform hospital accounts. This section will outline the main features of these problems as they provide the primary context for the emergence and shaping of the uniform accounting system.

From the early 1860s there was a major expansion of hospital facilities all over

Britain[12], but the greatest concentration of hospitals had always been in London and by the time of Burdett's publication of the *Uniform Accounts* in 1893, hospital beds and numbers in the Metropolis had mushroomed. The demand for hospitals had undoubtedly grown strongly over the period as improvements in medicine and nursing continued to change the image of hospitals from places to be avoided into havens of comfort and healing (Rivett, 1986, p.102). The dual introduction of anaesthesia and antiseptics had massively expanded the range of surgical techniques that could be carried out with a reasonable prospect of patient survival. In turn, the vast improvements in nursing care brought about by Florence Nightingale's training schools did much to increase the quality of bedside care and the comfort of patients. *The Lancet* eulogised about 'the wonders wrought for the relief of the poor' and asserted that 'without hospitals these wonders could not have been wrought (*The Lancet*, 22nd June, 1889).

5.4.1 Hospital Abuse

Externally, the campaign against the outdoor relief provided for by the poor law meant that those poorly paid unskilled workers, who could not afford to join a friendly society or provident club, increasingly turned to the charitable institutions to prevent themselves falling into destitution in time of sickness. While much of this care was provided for by the free and part-pay dispensaries the bulk of the consultations took place at the voluntary hospitals. It was particularly desirable

[12] The number of voluntary hospitals in England and Wales had increased from 130 in 1861, to 385 by 1891 (Pinker, 1966, pp.49, 69, 81).

for the sick poor that they should gain admission into a hospital, because admission meant that the burden of feeding and caring for them was not borne by their families (Abel-Smith, 1964, pp.152-5). However, many of those who sought help were acting under far less desperate circumstances. Many subscribers were businessmen who gained access to medical services for their employees at a fraction of the cost by means of the subscribers letter. The British Medical Journal (BMJ) recounts the story of one individual who's firm had been paying £300 a year for the services of the doctor, but since subscribing at £10 per year, to the local hospital, had dispensed with the services of the doctor (BMJ, 30th December 1876, p.870). This was one of the practices that came to be known as 'hospital abuse' and was another driver of hospital demand. The growth, however, was not entirely driven by demand, for there were significant pressures, mostly inside, but also outside the medical profession, to increase the number of hospitals.

5.4.2 The Special Hospitals

Significant amongst these pressures, was the desire amongst philanthropists to be associated with a new venture. Funds available to charities overall continued to grow throughout the Victorian period. It was, Frank Prochaska claims, 'the age of charitable societies' (Prochaska, 1992, p.1). But, although regarded as great and glorious, the large voluntary hospitals were, by this time, long established and there was, for newly wealthy philanthropists a higher possibility of significant involvement, with all the associated benefits, in a newly formed institution. Certainly, for

many doctors, the idea of opening a new hospital was an attractive option. The vast majority of the medical profession, despite receiving hospital training, had little chance of gaining a full hospital appointment; the zenith of medical attainment. For many it became clear that rather than face a lifetime of disappointment waiting for a position in an established hospital it made sense to canvass a group of willing benefactors and found a new hospital. The *British Medical Journal* (BMJ) put it like this:

> "How many men are there waiting outside the hospitals, doing dreary drudgery at the dispensaries; or, who, having at length been received within the coveted circle, are exhausting their best efforts in the outpatient's department, waiting anxiously for promotion and relief from thraldom of seniors! What these men, and many more who are not aspirants to the general hospitals, want is opportunity for independent work. And they want it while they are young, with energies unimpaired, still burning with the fresh spirit of original research" (BMJ, 13th August 1881, p.309).

Growth in hospital numbers was also increasingly supported by a new, research driven, medical phenomenon. Continuing medical advances created pressure for a move towards specialisation in medicine, but, established consultants were reluctant to allow the development of specialist departments as this inevitably put practice in the branches of medicine concerned beyond their jurisdiction. Rather than face a situation where they were forced to accept a shrinking area of practice, or alternatively choose their own specialism, they wished to retain the right to access all areas of medical practice. For junior doctors wishing to specialise, the situation was frustrating as they only had access to the patients of their own consultants and were unlikely to find enough patients suffering from any particular condition to

develop an area of expertise that would allow them to make a name for themselves. The almost inevitable result was the establishment of special hospitals (Abel-Smith, 1964, pp.157).

In the three decades from 1860, almost thirty special hospitals were opened in London alone. Most of these institutions were perfectly reputable, but their reputation suffered from the activities of a few that offered quack remedies[13]. Frustration grew with the growth of these institutions throughout the period until *The Hospital*[14] remarked in 1890 that the law allowed 'unrestrained license which permits any adventurer, who is so minded, to start a hospital for his own whim or profit' (*The Hospital*, 8th March, 1890, p.366). Such attacks were also supported by many involved in the large general hospitals, who perceived the burgeoning hospital numbers to be a threat to future funding. As the general hospitals and their medical consultants woke up to the potential threat, they began to develop their own special departments which, they claimed, obviated the need for separate special hospitals. By 1890, *The Lancet* was asking whether there was any justification for further development of special hospitals, because they had 'been practically superseded by the creation of special departments in general hospitals' (*The Lancet*, May 24th 1890, p.1130).

In particular, the special hospitals were heavily criticised for the cost of their management. *The Lancet* discussing a review of hospital costs observed that:

[13] A special hospital in Sheffield, for example, was noted for offering, at exorbitant fees, a cure for cancer.

[14] Burdett's Journal

> "anyone studying the table must be struck with the fact that during the nine years under consideration the expenditure on management at the special hospitals has increased from 15 to nearly 171/2 percent, whereas that at the general hospitals has remained almost stationary[15]" (*The Lancet*, July 14th 1883, p.72).

Losing control of management costs was the cardinal sin of a charitable institution. In the case of the special hospitals the magnitude of the sin was greatly increased by the fact that their management costs were already significantly higher than the general hospitals. Special hospitals, observed *The Lancet*, cost 'from 15 to 75 percent more per bed than . . . large [general] hospitals (*The Lancet*, December 22nd 1888, p.1241). Thus, the special hospitals were charged with gross inefficiency, as well as drawing charity away from the more established hospitals.

5.4.3 The Funding Crisis

The crisis in funding that the voluntary hospitals suffered in the late 19th century happened at a time when the large general hospitals had long been complaining of insufficient funds. Voluntary hospitals had long been prone to funding crises, but in 1868 Samson Gamgee, the surgeon to the Queen's Hospital in Birmingham[16], proclaimed that 'The sums now provided by the wealthy and middle-class, for the relief of the really destitute and suffering poor, are by no means sufficient' (Gamgee, 1868, p.25). The issue goes right to the top of the agenda as, increasingly,

[15] The exact figures were 14.9% to 17.4%. Management costs at general hospitals had also risen, but from the relatively much lower rate of 7.5% to 8.2%

[16] This makes Gamgee a contemporary of Burdett at the time when he was initially devising the system of uniform accounts. It seems probable, therefore in the light of the arguments made by Gamgee that, he was one of the unnamed colleagues that assisted in the preparation of the system.

the London hospitals found themselves with larger and larger deficits. The London hospital, situated in the poor East End, found itself having to make a five-year appeal to the city simply to raise funds to survive (*The Lancet*, May 4th 1878, pp.650-1). The newspapers, argued Dr. Mouat, 'contain piteous appeals to the public to afford additional funds to enable the authorities to occupy beds, emptied compulsorily, while numbers of sick people seek, and are unable to obtain, admission' (Mouat, 1881, p.82). By 1886 *The Lancet* reported a local MP as stating that 'most hospitals lived, like Mr McCawber, in a state of perennial expectation that something would turn up' (July 3rd 1886, p.55). Yet, the proliferation of hospitals continued, hospital income consistently failed to meet the expenditure and hospital managers increasingly struggled against each other to convince the benevolent public that theirs was the institution most deserving of donations.

5.4.4 The Outpatients Department

One device employed by hospital managers to convince public opinion of the efficiency and worth of the hospitals was the so-called 'abuse' of the outpatients department. Each year in the annual report the public were able to find details of the number of people treated, cured or relieved of their suffering by the hospital. An easy way to inflate this figure was to have an active outpatients department where hundreds of people would turn up daily to receive rudimentary treatment for their ills, but as the reputation of hospitals improved, increasingly large numbers of better off people began to take advantage of the free treatment available at

these facilities[17]. 'Hospital managers', argued *The Lancet* in 1889, 'delight in large statistics, and think that they tell well in the annual report, and strike the public . . . [and,] . . . outpatient relief costs little and tells much' (March 2nd 1889, p.433). Typically, the hospitals failed to distinguish between in and outpatients and, where such distinction was made, the details were given of the effectiveness of outpatient treatment. Many hospital consultants were also recognised as supporters of this practice, because it provided them with abundant material for teaching and research (*The Lancet*, March 13th 1869, p.365). This came to be recognised as an issue of national and international importance (Waddington, 1998, p.27), but much earlier it was ringing alarm bells with reformers and parts of the medical profession alike.

Some reformers were concerned about the apparent deception of the public, others, such as the Charity Organisation Society, with the effects that undeserved medical relief would have on the public morals (Rivett, 1986, pp.134-8). Some medical men were deeply concerned about the standard of treatment meted out in such departments. Gamgee described that 'patients are often passed before the prescriber at a rate varying from 60 to 120 an hour, inclusive of new cases ;–this being not a guess but an accurate numerical statement' (Gamgee, 1868, p.11). Others defended the 'enormous advantages' that were to be gained' from an educational point of view' (*The Lancet*, June 22nd 1889, p.1250), but such voices

[17] The chairman of the Metropolitan branch of the British Medical Association observed, at a meeting in 1869, that 'there were some 1,800,000 persons [in London] said to be receiving medical alms (*The Lancet*, March 6th 1869, p.343).

were relatively few. Mostly people were worried about the impact that the bad publicity was having on the reputation of the voluntary sector. Burdett is reported to have said that:

> "The abuses attaching to certain institutions did an enormous amount of harm and injustice to the best run hospitals, because the public did not know which was the best managed and which was the worst" (Clifford-Smith, 1883, p.109).

The Lancet agreed:

> "We believe that there will be no lack of support for hospitals if the administration of them is just and prudent, as well as humane. But if it is otherwise, and if hospitals lend themselves to careless and demoralising accommodation to people who ought to provide their own medical attendance, they will find that their subscriptions will fall off and charity itself will become more and more critical " (*The Lancet*, March 2nd 1889, p.1250).

Despite the ubiquity of these arguments, hospital outpatient departments continued to grow and to be regarded by general practitioners as 'evil', whilst for reformers they provided compelling evidence that the voluntary hospitals required a guiding hand. This was equally true of the last of the great hospital problems of the day to be discussed next: the complete lack of control over the location of new hospitals.

5.4.5 The Concentration of Hospitals in London

Whenever a new hospital was opened in London, the sponsors invariably wanted to locate the institution in the centre. Neither governors nor medical staff wished to travel beyond easy coaching distance from their homes and, invariably, they

lived in the centre of London, usually in the more fashionable areas (Abel-Smith, 1964, p.160). As a result, hospitals tended not to be opened in the suburban areas of the city, where hospital provision was often non-existent. All the major hospitals sat within a very tight area in the centre of London, but as a result of its massively expanding population, London had grown for miles in all directions. In 1881, Mouat clearly explained the problem:

> "Taking Charing Cross as a centre, there are, within a radius of half a mile, six hospitals ; within a mile, 19, and, in the circumference of the mile radius, a poor law infirmary in addition ; within a mile and a half, 31, with one poor law institution, and a lunatic asylum ; within two miles, 39, and 2 lunatic asylums; and within a radius of three miles from that centre, all the principal hospitals of London are placed. For the seven miles beyond this, to which the registration area extends and which contains the bulk of the population of London, there are barely a dozen hospitals, none of them of any magnitude or importance " (Mouat, 1881, p.78).

For the majority of the sick poor in London, a trip to the hospital was an expedition of several miles, through the streets, only to find on arrival that they had to wait in queues, sometimes of hundreds of people, for hours, in order to receive a consultation that would last for perhaps thirty seconds to one minute. Only if their case was found to be sufficiently interesting and potentially good for teaching or research purposes, would the unfortunate individual be selected for admission. Otherwise, they were typically handed a prescription and sent on their way (Abel-Smith, 1964: Rivett, 1986). Yet, it was virtually impossible to persuade doctors to attend hospitals that were located at any distance from the centre and since the consultants gave their time freely, no particular form of coercion could be applied.

By the time of Burdett's publication of the uniform system of accounts in 1893, the Metropolitan hospitals and their management had been under attack from critics and reformers for several decades. The problems of the proliferation and concentration of hospitals in the centre of London and the attendant funding crisis were, along with the perceived abuse of the outpatient departments, apparently beyond the capacity of hospital managers to resolve. What the reformers had long sought was an organising body, capable of controlling and directing the activities of hospitals in order to ensure that they were located where most needed and, crucially, that they were managed firstly for the benefit of the sick poor, the cause for which they were intended, and secondly that management was conducted to the satisfaction of the benefactors who provided the finance. However, in 1893 Burdett had already long been involved in a body that has, in recent years, been recognised as an early attempt to create just such an organising body: the Metropolitan Hospital Sunday Fund (Waddington, 1995, 2000: Prochaska, 1992).

5.5 The Metropolitan Hospital Sunday Fund Controlling Charity through Finance

5.5.1 The Genesis of the Sunday Fund

By the 1860s calls for reform were long-standing. In 1868 Gamgee was arguing that 'the present Hospital System of this country requires revision in the interests of the Medical Profession and the public' to the extent that 'the time is not far distant when the management of hospitals, . . . must form the subject of a comprehensive

inquiry' (Gamgee, 1868, pp.6-20). The realisation of an enquiry was far distant, but Gamgee was correct in his assessment of the state of the hospitals and the growing restlessness of reformers. The next year *The Lancet* outlined a proposal for the regulation of hospitals that would 'meet the requirements of the sick poor and the medical profession' (*The Lancet*, April 3rd 1869, p.464). The proposal outlined a form of state intervention and control, in which the state would provide an injection of funds to help ease the financial difficulties of the hospitals and would ensure that:

> "The hospital and provident dispensary should alike be under the control of a local governing board or committee, by which all the details of administration should be supervised. . . . the use of state funds for hospitals should secure State supervision and control ; and this as in the Education Department, should assume the form of a power to insist on certain necessary conditions, and to secure their continued fulfilment by inspection" (*The Lancet*, April 3rd 1869, p.466).

Echoing the arguments of Farr and Nightingale the article bemoaned the neglect of sanitary legislation and repeated calls for a 'uniform set of medical statistics' as a necessary part of the plan[18]. *The Lancet's* proposal was radical in the extreme. Few had any regard for the idea of state intervention in the hospitals, believing that the likelihood of the state being more efficient than almost any other system of organisation was remote. Nevertheless, the debate provoked by the article appears to have provided something of a wake up call to those opposed to state intervention

[18] The editor of *The Lancet* at this time was James Wakley, son of the founder, Thomas, and he appears to have carried most of his father's convictions about the need for sanitary reform and the maladministration and malpractice that existed within hospitals. In addition, the increasing use of scientific management techniques in business were beginning to spill into other areas such as medicine (Sturdy and Cooter, 1998) and increasingly came to influence the debates.

and the howls of opposition precluded the possibility of progress on that front. *The Lancet* was unrelenting, however, and raised alternative proposals for a central charitable fund raising body for London such as that seen in some other cities and while this plan was also opposed by many, the reaction was much less than for the earlier scheme[19]. Thus, within four years of the publication of the state control scheme, the Metropolitan Hospital Sunday Fund had been formed and the first annual collection made.

The Sunday Fund (as it was known) was a device whereby the organisers would on one Sunday at the same time each year, organise a collection in all the churches of the city and distribute the funds raised amongst the hospitals 'according to their requirements'[20]. The key element in this was of course that the organisers of the fund were those who would define the criteria upon which the decisions about the requirements of the hospitals would be made.

The institution of the fund in such a short period was a remarkable achievement, considering the powerful opposition aligned against it. Many of the voluntary hospitals had amongst their governors highly influential members of the aristocracy, who were concerned about the effects that yet another apparently competing fundraiser might have upon the collection activities of their own institutions. However, arguably the most powerful opponent of the scheme appears to have been

[19] The earlier proposal may have been a strategy on the part of Wakley to make his preferred plan seem relatively acceptable in comparison to the idea of state funded and controlled hospitals.

[20] The London fund was not the first to be formed and was in fact modelled on the scheme which had been started in Birmingham in 1858, copied by the organisers of the Manchester scheme and from there adopted by a number of cities up and down the country (Burdett, 1884, pp.7-8).

turned when, in 1872, Sir Sidney Waterlow, then Mayor of London, persuaded the Duke of Westminster that the scheme would not affect the normal donations and subscriptions to St. George's Hospital of which he was Treasurer. He also gained the support of the Bishop of London who had harboured reservations over the ability of the religious bodies to come together in pursuit of a single goal (Rivett, 1986, p.121). With such influential people in support of it, it became much easier to raise public awareness of the Fund and broaden its appeal, such that, by 1884, Burdett was claiming it had 'taken a very deep hold upon the consciences of the people . . . with the result that all kinds and conditions of men and women flock to places of worship on this one day in the year, in order that they may contribute their mite to the relief of the suffering poor' (Burdett, 1884, p.13). The aggregation of these 'mites' led to the accumulation of very considerable sum indeed.

5.5.2 The Qualification of Grant Aid

Even in its first year the Metropolitan Hospital Sunday Fund managed to raise the sum of £27,700, although this came in over a number of months rather than a single day. Despite the sum raised being far below *The Spectator's* estimate of eighty thousand pounds, much to the disappointment of *The Lancet* (February 12th, 1873, p.280), it was sufficient to attract the attention of London's hospital managers, who were quick to make overtures to the Fund. The attention of hospital managers, was arguably, also drawn by the enormous publicity generated by the fund and by extension to its espoused primary function, the generation of funding

for the voluntary hospitals. Burdett had no doubt that the Sunday Fund and its sister movement the Saturday Fund[21] had 'undoubtedly attracted a greatly increased amount of public attention to the hospitals, and have by this means caused indirectly a considerable addition to the funds placed at the disposal of the managers of these charities' (Burdett, 1884, p.12). The amounts generated by the Fund itself continued to grow throughout the last quarter of the 19th-century, until by 1895 the annual collection was drawing in over sixty thousand pounds. From the start, however, reformers both inside and outside of the Sunday Fund had been very clear that they did not want the grants to be given unconditionally (Burdett, 1884: Waddington, 1995).

It was argued by many, especially those involved in the administration of the voluntary hospitals, that the fairest way to distribute the funds raised by the Sunday Fund was simply to allocate pro-rata on the basis of the number of beds in the hospital. The reformers had no such simplistic scheme in mind. Instead they pressed the Distribution Committee to seek more detailed and reliable information about the activities of the hospitals. But, cognizant of the failure of Farr and Nightingale to implement their system of uniform statistics they sought alternative sources of data that were unlikely to offend the sensibilities of the medical profes-

[21] The Saturday Fund had a different emphasis from the Sunday Fund in that it collected donations from working men and women in their places of employment and, like the Sunday Fund, subsequently gave grants to the hospitals, in return they sought access to the hospitals for sick individuals who had made contributions. Cherry has observed that many working men's groups towards the end of the 19th-century fought for representation on hospital boards of management in return for donations, but the Saturday Fund generally seems to have avoided this course, (Cherry, 1996a,b).

sion. The obvious source of information was the annual report which was already produced by all hospitals and included data on both the financial and medical activities of the institutions. However the reports were prepared independently by each hospital and the information included therein, as well as the method of its compilation, was entirely at the discretion of the authorities of each charity. Categories of income and expenditure were created and compiled in myriad ways and this lack of consistency and a number of other practices employed in the preparation of these reports had long been the subject of criticism.

5.5.3 The Unreliability of Hospital Accounts

As far back as 1834 a Parliamentary Medical Committee had recognised the difficulties of obtaining reliable information about the costs and financial requirements of voluntary hospitals (*The Lancet*, 1834-5, Vol. 2, p.669), but by the last quarter of the century the unreliability and abuse of the accounts was becoming a major issue for those concerned with reform of the hospitals. 'It is a matter of great notoriety', complained *The Lancet* in 1882, 'that the records of . . . [the hospitals] . . . are so carelessly kept as to be valueless . . . [and] . . . that their accounts are not subjected to any reliable audit' (April 29th, 1882, p.719). The need for 'minute and accurate detail' as the 'very lifeblood of statistics' was observed and with regard to annual reports the editorial stated that:

> "unless the publication affords the requisite basis for apportioning to each institution the different items of income and expenditure under their exact heads and the units to which the figures apply are themselves correct,

> tables[22], however carefully constructed, can scarcely convey an accurate estimate of the state of those institutions for positive or comparative purposes." (*The Lancet* April 29th, 1882, p.719).

These sentiments were echoed by Mouat and Saxon-Snell in their 1883 book, *Hospital Construction and Management*. Referring to Burdett's (1881) comparative analysis they argued that there was no greater need than to introduce central control over the way that the accounting and reporting practices of the hospitals was carried out. Burdett's figures had suggested that, even within the general hospitals, the cost of management had ranged from 2% to 27% of income and that the average weekly cost per patient ranged from 9s.4d. to 45s.2d. (Mouat and Saxon-Snell, 1883, p.21). The data analysed across all types of hospital displayed even more extravagant variation. It was clear that either there were enormous differences in the cost and efficiency of different institutions or the unreliable and unsystematic preparation of the accounts was creating such apparent differences. Whatever the case the reformers felt this situation to be unacceptable. Mouat and Saxon-Snell were also vocal in calling for this central control to extend into the keeping of medical records. There appeared little difference in their conception of the purpose of financial and medical data. Both were collected in order to examine the performance of the institutions concerned: the financial data examined the pecuniary requirements of the hospital and its ability to raise sufficient funds and; the medical data demonstrated the efficiency of the hospitals in the performance

[22] The author was referring to comparative tables that were derived from the annual reports of the hospitals. The particular example under discussion in this instance was the volume prepared by Burdett in his monograph *Hospitals and the State*, published in 1881.

of their primary function, the healing of the sick-poor (Mouat and Saxon-Snell, 1883, pp.15-18). Incensed by the continuing intransigence of hospital management with respect to the publication and provision of reliable information the reformers began to focus on specific practices that they deemed to be questionable.

The main thrust of the arguments focused as much upon the recording of income as it did upon the expenditure. Some practices were highlighted as clearly malign. For instance, in a paper entitled Hospital Extravagance and Expenditure (Michelli, 1888)[23] it was claimed that some hospitals were concealing the cost of their fundraising efforts by deducting the costs of collection[24], printing, stationary, commission and advertising from the monies raised and declaring only the balance as income in their accounts. The benefits of this practice for those involved were clear: it was possible for a hospital's managers to significantly raise the profile of their hospital through advertising and collecting activities, while simultaneously concealing the cost of those activities and protecting themselves from claims of inefficient management; thus would their fame spread, while their income was maintained at a level modest enough to maintain the necessity for further appeals. The obvious corollary to this was that other hospitals in the locale of the offender were likely to suffer diminished income as a result of the more extensive collections of the offending institution. This practice was arguably not only poor accounting practice, but also morally questionable and as such was easy to con-

[23] Michelli was, at this time, the secretary of the Seaman's Hospital at Greenwich and was, therefore a colleague of Burdett.

[24] Collectors were often paid a commission on the money that they raised.

demn (*The Lancet*, December 22nd 1888, p.1241); more complex issues surrounded the treatment of legacies in the hospital accounts.

It was typical for hospitals, in relatively affluent times, to retain income received in the form of legacies and bequests and invest that money to provide a regular revenue stream for the future. This was applauded by many as sound practice, designed to work towards a time when the hospitals would require little or no contributions or donations, but would instead be able to provide for themselves out of income from investments (Rivett, 1986). However, when income was in short supply the hospitals often disposed of such assets in order to make up the shortfall. This practice enraged many of the interested parties who saw it as grossly irresponsible:

> "No hospital is worthy of public support when it is conducted on such a vicious system as this, and the charitable would do well to inquire whether the laws of a hospital provide that not only shall no committee of management, but no general court of governors, have power to determine on any measure relating to the disposal of any money beyond the current income and expenditure of the hospital, without ten days notice shall have been given to such court, nor until the intended sale of stock shall have been specified in the notice. No stock, funds, shares, or securities should be sold, assigned, transferred or otherwise disposed of without the authority of the governors, testified in writing under the common seal fixed at a meeting of governors specially convened for that purpose." (*The Lancet*, November 3rd, 1883, p.790).

Rather than expend the capital stock of the institution, it was felt preferable that managers should restrict its activities such that the ordinary income was sufficient to cover the cost, thus preserving the income from capital for future years. One of the main difficulties for observers was that none of the hospitals kept

a capital account and the treatment of investing activities was typically obscure.

This lack of awareness of the results of capital expenditure made others, even more wary of the use of legacies. All too often surpluses generated by large bequests were used to finance major expansion programmes that were deemed inappropriate by reformers, especially amongst those hospitals located in the centre of London where more hospital provision was scarcely required. Constantly frustrated by the empire building of the hospital managements and the obscurity of the accounts (*The Lancet*, January 19th 1889, p.131), reformers continued to press for changes to create a consistency of treatment in the accounts that would allow real evaluation of the financial position and the performance of the hospitals. The culmination of these efforts was the adoption of Burdett's system of uniform hospital accounts by the council of the Metropolitan Sunday Fund, but this had not been an easy task; rather it was the outcome of an effort extending over three decades.

5.6 The campaign for uniform hospital accounts

5.6.1 Vital and Economic Statistics

Fleetwood Buckle's publication of *Vital and Economic Statistics of the Hospitals, Infirmaries, & c., of England and Wales, for the year 1863* was the first book to highlight the discrepancies in average costs that arose either through management, or through accounting variations. Buckle stated that his work had been compiled with the aim of 'facilitating the comparison of the internal economy of the various medical charities in the kingdom.' (Buckle, 1863, p.v) and he quickly identified that

the scale of activity was worthy of much closer attention. In 1863, he observed that the medical charities had treated 'nearly two million patients at a cost of about half a million sterling'. 'Surely this sum' he argued 'is large enough to warrant careful supervision' (Buckle, 1863, p.viii). Suggesting that there should be some central control over the hospitals Buckle implied that in his opinion, properly comparable accounts could be taken as an adequate substitute for Government intervention:

> "The wide variation in the average cost of patients, or, in other words, in the utilisation of the funds, would point to a great necessity for a general inspector, appointed by Government or some central body, to act as a check upon the local committees, and to endeavour, by annual comparison with other institutions similarly situated, to economise or obtain the greatest good out of the least possible expenditure of money ; or, at all events, to secure a proper and uniform set of records being kept in each charity" (Buckle, 1863, p.vii).

Buckle's efforts did not go unnoticed, but it was some time before the campaign for uniform accounts really got under way and a focus upon the financial aspects of hospital performance began to emerge in the medical press (see for example *The Lancet*, October 3rd 1868). Pursuing his arguments through the public health branch of the Social Science Association (SSA), the breakthrough was eventually made six years after the original publication of his *Vital and Economic Statistics*.

5.6.2 The Social Science Association (SSA) and The Lancet

Early in 1869 a letter from Buckle was read to a meeting of the SSA. The letter contained information recently gathered by Buckle from twenty-two of the Metropolitan hospitals and made comment as to their financial condition and their perfor-

mance[25]. The accuracy of the information was immediately challenged by Joseph Wilkinson the secretary of Saint Mary's Hospital and in the ensuing discussion the difficulty of comparison of different hospital accounts became obvious. The proceedings were reported in *The Lancet*:

> "It appeared all but impossible to make any comparison between the expenditure of the various institutions, owing to the entire want of uniformity in the reports and accounts. The meeting unanimously resolved that it is desirable that these be presented in a uniform shape ; and a committee was appointed to draw up a form of statement of accounts, which may be recommended to the various hospitals from this section of the Association, and that the committee be authorised to communicate with the authorities of the hospitals, and subsequently report to the Society upon the subject" (*The Lancet*, January 30th 1869, p.163).

The SSA was highly influential and the resolution made that night gave credibility to the reformers campaign that it had previously lacked. *The Lancet* editorial was quick to fasten on to this event and add its own support to the cause:

> "We conceive that no greater boon could be conferred upon these institutions and the public than a system which would enable everyone to see exactly how the funds of the public hospitals are dispensed . . . there are great discrepancies between the cost of large and small hospitals in the expense of food, nursing, and general management ; that, in some cases, capital is trenched upon to meet urgent difficulties, whilst in other cases these difficulties are met by special appeals." (*The Lancet*, January 30th 1869, p.163).

The Lancet couched its support of the proposal in terms of the discrepancies between large and small hospitals, but this may have merely been a placatory device to imply that the real targets of the system were the proliferating special hospitals, a

[25] *Vital and Economic Statistics* never gained the status of an annual publication and Buckle's work was published only sporadically after that. However, the concept of a comparative publication reviewing the data of all the hospitals was not lost on Burdett who picked it up initially with his publication in 1881 of *Hospitals and Charities of the World* and later with his annual series *The hospitals and Charities Yearbook*.

genuine problem and one that also threatened the income of the major institutions, thereby eliciting their support. The editorial was careful not to offend any of the powerful individuals involved in the management of the great hospitals, stating that their support for the scheme implied no 'imputation of maladministration or culpable waste' (p.163). Yet, they were not beyond raising the spectre of the alternative of government intervention:

> "We have no great faith in Government auditors, but we think the governors of the various hospitals would do wisely to assist the committee now appointed, in order that the reports and accounts might be uniformly made out, and that they should be provided to an independent professional auditor provided by themselves." (*The Lancet*, January 30th 1869, p.163).

The implied threat of state intervention demonstrated that *The Lancet* felt the situation to be a serious one that required action of some kind, preferably achieved with the co-operation of the hospitals and the reformers, rather than a solution imposed by government that could potentially leave both groups out of the control loop. That they were prepared to make mollifying noises towards the great hospitals and their sponsors is perhaps not surprising; their main aim was to realise the inception of a uniform system of accounting and gain the support of the most powerful institutions would greatly assist that process. Once the system was in place it would reveal significant differences in costs and activity, wherever they occurred, in institutions small, or great, equally.

Despite the reassurances, voices of protest decried the slur that they perceived had been made against their 'noble charities' and questioned the accuracy of the

information. Buckle was forced to defend his paper stating that he 'did *not* impute any fraudulent or dishonourable conduct to the managing bodies of our metropolitan medical charities : the results are bad enough without' (Buckle, 1869, p. 278, original emphasis). Stating that the information that he had used had been provided to him by the secretaries of the hospitals concerned he offered that he was 'not so discourteous as to suspect them of wilfully misleading [him]' (p.278). His main purpose he argued was simply to promote the arguments that he had been making for the last five years; stated as:

> "1st. That the present reports were unsatisfactory, as they were not kept on any uniform plan, rarely giving the average number of beds occupied, or the actual amount expended for the year (old debts &c., being included in the cash account),–hence it was almost impossible to use them for comparison.
>
> 2nd. That a Government official, public auditor, a committee, or some central directing body should have authority to supervise them, and insist on uniformity.
>
> 3rd. That these revised reports be so clearly drawn up that the public should be enabled to check the expenditure of their money.
>
> 4th. That all the working medical officers be remunerated, and that the resident physician's or surgeon's position be made of more importance, and sufficiently paid to induce good men of experience to accept the post, not merely as an introduction to practice, but as a permanent life appointment[26]." (Buckle, 1869, p.278).

Whatever the arguments advanced by the opponents of the scheme it was almost certainly the suggested oversight by some unknown central authority that was the major concern: the hospitals were unlikely to surrender their autonomy without

[26] Perhaps in this last aim it is possible to discern some of Buckle's motivation as he was one of those doctors who had never managed to secure a lucrative hospital appointment and, as a consequence, sought to change the system by which such appointments were made. The changes he sought, although eventually to come about, did not happen in time for Buckle and he eventually gave up his campaigning and left Britain for South America.

significant resistance. Yet, the tide was starting to turn against them. After the Social Science Association's decision to investigate the form of accounts, other interested parties began to take interest.

5.6.3 The Expansion of Interest in Uniform Accounts

The group most disadvantaged by expansion of the number of hospitals and, in particular, hospital outpatient departments were the general practitioners (Abel-Smith, 1964: Rivett, 1986). The Metropolitan Counties Branch of their increasingly influential professional body, the British Medical Association (BMA) very quickly came down on the side of the SSA stating that they were seeking to identify 'whether any and what steps can be taken to promote an uniform system and publication of hospital accounts, and of the records of mortality and sickness in hospitals' (Henry, 1869, p.262). The cause was taken up later that year by the Statistical Society, when its president, Newmarch[27], suggested that 'periodical returns should be furnished by hospitals in the metropolis and large towns, of such a nature as will admit comparison of the efficiency and cost of relief afforded in each' (Newmarch, 1869, p.831). Seeking to ensure an effective check on the 'perfectly enormous' income, in order to discern where 'cost was highest and, efficiency the least', Newmarch was also careful to add that 'no undue revelations were needed or desired', but that 'the public have the clearest right to be satisfied that the money they set aside for the relief of sickness and misfortune is put to the best possible

[27] William Newmarch (1820-82) was a banker in the City of London with wide interests which included being editor of the *Journal of the Royal Statistical Society* and its President from 1869-71.

uses, and in the most economical manner' (Newmarch, 1869, p.831).

Wilkinson, the Secretary of St. Mary's Hospital who had been critical of Buckle's figures, appeared ostensibly to have joined the reformers when in 1870 he conceded that a uniform system of accounts would tend to reduce expenditure by facilitating easy comparison between establishments. However, he did supply an analysis of forty-six London and provincial hospitals that he claimed demonstrated that the large discrepancies seen in previous analyses had to a great extent been rectified (*The Lancet* March 26th 1870, p.457). Such claims were not unusual and were possibly intended to take the momentum out of the campaign for uniformity. The attempts may have been effective had it not been for countering *Lancet* editorials that pointed out that due to the way that 'reports are drawn up after a different fashion for nearly every hospital' and that 'balance sheets differ immensely in the amount and the character of the information afforded ; and the items of receipts and expenditure are classified on so many different plans, . . . the task of drawing correct conclusions from the reports as a whole is by no means easy' (*The Lancet* September 23rd 1871, p.442). Thus, by the mid 1870s the reformers appeared to have gained the moral high ground but it availed them little in their objective of achieving a uniform system of accounting because they had no effective way of *forcing* the hospitals adopt a system and they were, in general, ignoring the calls for voluntary adoption.

5.6.4 The Sunday Fund and Uniform Accounts

The Metropolitan Hospital Sunday Fund had, as detailed above, begun its collections in the 1870s and was making allocations of funds on the basis of the accounts supplied to it by the hospitals. Initial distributions tended to focus on the deficits of the hospitals with the grants going to those deemed most needy. However, in 1879 it had been running for only a few years when the distribution committee, disappointed with the quality of the information they were receiving, started to seek more reliable data from hospitals, not just about their financial position but also about their actual performance, particularly with respect to the number of patients treated (*The Lancet*, June 28th 1879, p.922).

The difficulties being experienced by the Sunday Fund's distribution committee increased the frustration of those seeking reform of the hospitals. In 1881 Mouat[28] began to publish in *The Lancet* a series on the management and construction of hospitals. Mouat, who was exceptionally well travelled, argued at length for state control of the hospitals, observing that 'in most foreign countries the central and superior control is in the hands of a governmental administrative agency' (Mouat, 1881, p.942). He also argued that there should invariably be representation, on the committee of management of hospitals by 'men possessed of an adequate knowledge of finance, of structural arrangements, and of such economic principles as are required in the general control and direction of an establishment' (Mouat, 1881,

[28] Mouat, as a former Deputy Inspector General of Hospitals, was an informed voice and, as Vice-President and Foreign secretary to the Statistical Society, was deeply involved in the movement to get reliable statistical information upon which to make judgements about hospitals.

p.943). Hospitals, according to Mouat, should be run on more businesslike principles to maximise their economy and efficiency. Of the necessary mechanism to achieve this control Mouat was in no doubt:

> "I know of no good reason why the hospitals of London and other great cities, should exhibit such very different risks to life in similar circumstances, diseases and accidents, as they do now and have done for long past ; and why a proper uniform system of hospital record in all departments of their administration should not be as compulsory as customs, trade, and other economic returns, in matters of far less general and scientific interest" (*The Lancet*, January 30th 1869, p.163).

He went further, stating that the day-to-day running of the hospital should be in the hands, not of a committee of lay contributors and local officials, but a professional superintendent. Thus, the control of operations would be ceded by the committee of management and their role would be removed to one of oversight.

These radical proposals must have caused a stir on many hospital committees. They were seriously discussed in the press and followed up by a monumental work of Mouat and Saxon-Snell that pressed the case even harder (Mouat and Saxon-Snell, 1883). The debate began to heat up through the 1880s and the reform movement (Burdett in particular) became less cagey about criticising recalcitrant hospital committees:

> "there are twenty-eight medical institutions [in London] ostensibly ministering to the requirements of the public, which are so conducted that the Council of the Hospital Sunday Fund has not yet been supplied by the authorities of these institutions with the small amount of evidence of their efficiency which the Council require before it will consent to entertain an application for a grant" (*The Lancet*, March 10th 1883, p.415).

The article by Burdett talked about the extravagant, reckless and uncontrolled financial administration of committees of management that were self-elected, irresponsible and resentful of outside criticism. This was an unprecedented level of attack[29]. It was perhaps even more notable for the way it posited the idea that those institutions that did not submit accounts to the Sunday Fund were the ones that were most likely to be perpetrating financial and medical abuses. This approach attempted to endow the Fund with an authority that, arguably, it had not previously held in the public mind and although Burdett studiously avoided mention of state intervention, he raised the concept of a central controlling authority that would supervise the erection, extension and administration of hospitals throughout the country. By this means they could not only 'encourage improvement and check abuses', but could 'guide the public mind in the disposal and distribution of its eleemosynary aid' (*The Lancet*, March 10th 1883, p.415).

Burdett's promotion of the role and status of the Sunday Fund was a key element in the movement to promote uniformity. The long slow progress made in the campaign through the 1880s ultimately showed signs of coming to fruition in 1890 when the frustration of the council of the Sunday Fund with the information supplied to them and the lack of co-operation of hospital management committees

[29] Throughout the 1880s the discourse became more critical of those activities of the hospitals that were deemed to be less salubrious, ethical and economical and regularly floated and discussed the idea of uniform accounts as a check on this kind of activity. When, in the middle of the decade, the Social Science Association broke up into separate organisations *The Lancet* was quick to remind the nascent British Hospitals Association (BHA) that there was 'no better way of promoting soundness in hospital administration . . . than by trying to introduce a sound and uniform system of account-keeping' (April 24th, 1886, p. 797). Thus, although the progress through the decade was painfully slow, the reformers were careful never to let the topic fall from the agenda.

caused them to act. *The Lancet* reported that;

> "It has long been felt by some of the members of the Council of the Hospital Sunday Fund and by others outside that body that the Council should exert its influence to secure the observance of a more uniform state of keeping hospital accounts . . . It looks as if something might now be done in this direction" (August 9th, 1890, p.294).

The distribution committee of the Sunday Fund had finally passed a resolution calling for a meeting between themselves, the Lord Mayor and the managers of the leading hospitals with a view to 'consider the possibility of arranging for some uniform system of accounts'[30] (*The Lancet*, August 9th, 1890, p.294). *The Lancet*, seeing the prospect of success, became cautious over the *nature* of success. It was important not just to have a uniform system of accounts but to have one that generated the kind of data that they sought: 'The more carefully and slowly the plan of accounts is laid down, the more likely it is that a just comparison will become possible of the expenditure and the administration of different hospitals.' (August 9th, 1890, p.294). Clearly fearing that some superficial compromise would be reached *The Lancet* began to turn the thrust of its editorials towards its preferred purpose and form for the uniform accounting system.

[30] The exact reason for the length of time taken by the Sunday Fund is obscure. It is clear that there was a strong internal movement for the Fund to pursue this end earlier and certainly there was evidence that for protagonists like Burdett and Wakley it was crucial for the Fund to realise its potential as the central body that could police the activities of the hospitals. However, the Lord Mayor of London and Vice-President of the Council of the Fund, Sir Sydney Waterlow, appears to have been reluctant to pursue the reform objective very strongly. Whether he felt that the Fund needed time to become established before it could flex its muscles, or whether he felt constrained by the reassurances that he had given about the purpose of the Fund in order to establish it in the first place, Waterlow was slow to use the Fund's influence. Ultimately it appears that it was the sheer weight of criticism generated by the reformers that ultimately turned the tide against the hospitals.

In 1891 the agenda was firmly transferred from whether or not a system of uniform accounts should actually be implemented to what shape the system should actually take. Basic accountability for the funds of the hospital was quickly identified as central but, paradoxically, hardly worthy of much consideration. As *The Lancet* commented rather dismissively: 'the statements published should be given with such fullness and detail as to make fraud and peculation as nearly as may be impossible, are so obvious as to be universally recognised' (July 18th, 1891, p.140). More worthy of consideration was another function of the publication of uniform accounts; 'namely, that a properly devised form of account may be made to conduce greatly to the economy and efficiency of management by exhibiting the comparative results obtained by a given expenditure in various institutions' (p.140). A simple presentation of the expenditure account was unhelpful, it claimed, even when 'precise agreement' had been reached concerning the classification of items. Using butcher meat as an obvious example, it argued that it gave only a partial view to know how much had been spent on a specific quantity of meat, because butcher's meat:

> "may be purchased for the supply of patients, or of domestic servants or of the nursing staff, or of the secretary and his family, or of the medical officers, and it is evident that a more accurate representation of the working of the institution would be given by entering the value of allowances of such food made to any of these officers as salaries than by including them, as is commonly done, under one undiscriminating head" (*The Lancet*, July 18th, 1891, p.140).

The same principle could be applied to rent and many other items of expenditure and only if the statements 'distribute[d] the expenditure under the various

departments' of the hospital's activity could the public discern how much of the total 'subserves directly the work of the charity, and how much is devoted to bearing the burden of incidental expenses' (p.140). A principal purpose of the accounts was, for *The Lancet*, to demonstrate that much benevolence was spent on the lavish maintenance of individuals whose supposed parsimony and altruism was held to be one of the cornerstones of the voluntary hospital movement. By exposing the scale of expenditure that went to maintain the staffs and other hangers on, it hoped that it could 'bring questions of economy into a clear light and educat[e] the inferior managers up to the level of their betters by that most effective of all methods-public criticism in the light of comparative results' (p.140). Relentlessly the critiques published by Burdett, Wakley and others such as Mouat (despite the interminable stalling of hospital management committees) maintained the pressure on the hospitals and kept the issues before the public, driving the debate on the form that the accounts should take onto those factors that they deemed most important.

5.6.5 Two Competing Systems

By the end of 1891 there had emerged two forms of the schedule to be potentially used as the basis for the hospital accounts: one was promoted by *The Lancet* the other was the work of the committee of hospital secretaries, convened by the authorities of the Sunday Fund. *The Lancet* claimed it was keen to examine the commonalities and differences between the approaches, but initially only developed

the arguments for its own version. Uniformity of presentation was felt to be an important feature of both systems. In both cases hospitals would be required to report to the Fund on a common schedule supplied as part of the application for a grant. Referring to the way in which legacies could currently be found entered, either wholly or partially, on one, both, or neither sides of the account, the editorial stated that all but one of these methods must be wrong as; 'where one succeeds in giving the public a clear view of the material facts, the other[s] fail' (*The Lancet*, November 7th, 1891, p.1063). Uniformity would eliminate such issues and allow the public the necessary clear view. The clear division in their scheme of income and expenditure into 'departments' was intended to show the magnitude of income received and whether it was reliable or casual. Similar treatment of expenditure was intended to show how much of the maintenance cost was attributable to patients, staff, buildings, improvements and investments (p.1063). The scheme put forward by the journal had 'the merit of serving to bring the foregoing points into prominence, and this . . . [is] the chief merit to which a schedule of this kind can lay claim' (p.1063). Thus *The Lancet* expounded the virtues of its scheme while, the other scheme put forward by the hospital secretaries was treated less favourably.

The scheme of the hospital secretaries had failed, it seemed, to 'systematise the entries on any other principle than that of uniformity in the presentation of accounts' (*The Lancet*, December 5th, 1891, p.1288). The stress was, therefore, laid heavily upon the definition and meaning of items of expenditure and their

subsequent classification into the various categories. This was not, it was claimed, intended to be an improvement, but rather was just a good example of the kind of approach already in use which 'did not meet the case for which the other [*Lancet* proposal] was designed' (p.1288). Once again attention was drawn to the unsophisticated treatment of legacies as part of general income. On the credit side, as well as a lack of attention to the reasons *why* expenditure was being incurred, criticism fell upon the way in which 'capital outlay [was] inextricably mixed up with ephemeral outlay' (p.1289) making it impossible to draw conclusions 'of any importance'[31]. It was clear that Wakley at least felt that the secretaries' proposed system was only a superficial improvement on what was currently in existence and feared that it was this system that would be adopted.

5.6.6 Adoption

Feelings must have been mixed, therefore, when, early in 1892 the committee of secretaries presented a provisional plan of accounts to the Council of the Sunday Fund and the Council resolved to adopt it there and then. The need for a 'fuller consideration and the possibility of consequent revision . . . were clearly recognised', but the sheer inconvenience of having to deal with the myriad of presentations

[31] The hospital secretaries were furious at Wakley's editorial and denied that they were finished working on their form of the accounts (*The Lancet* December 12th, 1891, p.1375). Enquiries into how the sample form had been leaked to the journal revealed that Burdett had been the culprit and that he had also revealed that the work of the committee was less than harmonious. Presumably, the few such as himself who sought to implement a more sophisticated accounting system were in disagreement with the majority who did not wish to see such a system in place. The committee censured Burdett and stated that he had no authority to present the scheme as the work of the committee or discuss the difficulties attending its operations (*The Lancet* December 19th, 1891, p.1401).

from the hospitals was so great that the officers of the distribution committee persuaded the council that it was important to implement a system as soon as possible (*The Lancet*, February 6th, 1892, p.323). *The Lancet*, doubtless cognisant of the possibility that the effort might dry up at that point began to adopt a mollifying tone towards the committee of secretaries, praising the 'considerable sacrifice of time and trouble' and the 'large amount of special knowledge' that had been brought to bear on the problem (p.323). Exhorting the committee to continue its work, *The Lancet* also opened up another front in their struggle with the hospitals by promulgating the notion that the results of the committee could only be partial as the views of the public on the subject of the shape of uniform hospital accounts had not been collected for due consideration.

The stamina of the reformers, with regard to the achievement of their goals, was remarkable in itself. By 1892 the campaign in the press, sponsored by people such as Buckle, Burdett, Mouat and Wakley, had been running for almost three decades and in part they had been successful. The adoption by the Metropolitan Hospital Sunday Fund, however tentatively, of a uniform system of accounts, meant that any hospital that wished to receive a grant from the fund would have to present its financial information according to the uniform plan. That the plan adopted did not in their opinion go far enough was made plain by *The Lancet*, but nevertheless, their preliminary objectives of winning the argument as to the necessity of uniform accounts and achieving a mechanism for the adoption of the accounts had been achieved. That there was a body of opinion that felt that the accounts needed to

be more focused on the internal management of hospitals is clear, but equally clear from the publication made the subsequent year by Burdett of the proposed system was that much progress had already been made.

5.7 Summary and Conclusion

In 1893 Burdett's publication codified the system of uniform hospital accounts as it then stood, with additional suggestions for good practice added by him. The emergence of this accounting system was not the outcome of some incremental improvement in accounting. Instead it was the product of a political process in which those who sought reform of the voluntary hospitals attempted to create a system that did more than simply report on the financial position of the institutions concerned, rather it attempted to provide the reformers with a technology that structured the activities of the hospitals in a way that aided the process of reform. Many within the hospitals resisted (most often passively) the implementation of this system.

The ideal system of Burdett and *The Lancet* was one that would both penetrate and structure the organisation, dividing income and expenditure not only into classes of item but also into categories of use. Such a structure would allow analyses of how and why the expenditure was being incurred as well as on what it was being spent. Further, it would potentially allow for the creation of the kind of supra-national structure around the hospitals that has been identified by

other researchers on uniform costing and accounting systems in different industries (Walker and Mitchell, 1996: Mitchell and Walker, 1997: Walker and Mitchell, 1998), and locations (Gorelik, 1973). Within such a structure where the data is provided from a common platform measures of performance, typically averages, could be devised that explored issues deemed relevant by anyone that had access to the data. Those organisations that were found to be diverging from what would be perceived as normal patterns of cost and activity would become visible and the managers of those organisations would be liable to have their activities questioned and critiqued forcing them to re-examine their practices and thereby pressing them to conform to the norm. Thus, those that controlled the form of the accounts would potentially be able to direct the reform agenda to those issues that they held most important. Obviously, for such a system to work, the institutions concerned would have to adopt it and allow the data to be collated by some central body and for 19th century reformers this remained the greatest challenge.

The rhetoric deployed in favour of the system was focused on economy and efficiency; seeking to maximise the 'good' that could be achieved from the finite resources provided by philanthropy. Despite such laudable aims gaining any sort of acceptance for a system of uniform accounts was an uphill task. It is unlikely that they had a conception of the surveillant power of accounting, but the managers of the hospitals would have been fully cognisant that the inevitable result of adopting such a system was to provide their critics with the information that they needed to criticise them effectively. Unsurprisingly therefore, hospitals' manage-

ment boards were reluctant to engage in the system and were equally reluctant to concede that there was any need for it. It was necessary, therefore, for reformers to find mechanisms whereby they could apply pressure to the hospitals to comply with the implementation of the uniform accounting system.

They found much of what they needed in publicising the problems and issues that they felt were most in need of reform. Since its inception in the 18th century the voluntary movement was regarded by all to be a great achievement and a crowning example of all that was best in British society. Since the 1820s the Wakleys through *The Lancet* had begun to erode that perception with their critical editorials ably aided and abetted by other like minded people such as Farr and Nightingale in the 1850s and 1860s and Buckle, Burdett and Mouat after that. By the last quarter of the 19th century the discourse of hospital problems had moved beyond the occasional editorial and was full blooded and prominent both in the press and the public mind, particularly in London. The proliferation of the 'inefficient' special hospitals, diluting the funding of the established hospitals and increasing the concentration of hospitals in the centre of the city, was blamed on the nepotistic and corrupt practices of the medical consultants to the great voluntary hospitals as they sought to protect their empires and their incomes (Abel-Smith, 1964: Rivett, 1986: Woodward, 1974). The inevitable scramble for the cash that was available led to the 'abuse' of the outpatients departments as hospitals vied to demonstrate that they were effectively treating large numbers of patients, leading in turn to claims of mismanagement. The ability of much of the general populace to gain

access to this free medical treatment (no matter how poor its quality), led to bitter complaining from general practitioners who found their incomes negatively affected as a result. Thus, hospitals became the focus of a discourse of mismanagement and inefficiency, creating significant demand for reform among the cognoscenti. Yet, this alone was insufficient to motivate reform because the majority of the public still held the hospitals in high regard and continued to fund them.

The key factor that allowed the reformers to create the mechanism whereby they envisaged they could achieve their goals was that the available funding was insufficient for the task. With the promotion of the Sunday Fund through the medium of *The Lancet* the reformers had potentially created the lever they needed to request hospitals to produce accounting information that would enable analyses of their activities. The composition of the council of the Fund was not entirely in the hands of the reformers, however. To gain credibility for such an organisation it had to be seen to be balanced and open handed in its aims and its membership. Thus the Fund was slow to pick up on the call for uniform accounts and instead concentrated on what was ostensibly its main aim of raising money for the hospitals (Waddington, 1995, 2000). It quickly became clear to the distribution committee of the fund that the information that they were receiving was inadequate to make any reasonable decision as to the merits of awarding grants to particular institutions. This fact had been made clear more than a decade earlier by Buckle, around the time that Farr and Nightingale were finally failing in their attempt to gain acceptance for their uniform hospital statistics and had been taken up in a campaign in

The Lancet.

Concentrating on the inability of the observer to discern how income was composed and why expenditure was incurred, the editorials and articles highlighted the impossibility of discerning where good and bad management was occurring and the subsequent impossibility of its rectification. The involvement of a committee of the Social Science Association boosted the campaign, but progress was slow, taking several decades of increasingly critical rhetoric until the frustration of the distribution committee of the Sunday Fund led it to accept that uniform accounts were the necessary remedy. Despite apparent delaying tactics by the committee of hospital secretaries, a system of uniform accounts was adopted in 1892. However, the reformers were not pleased with the outcome, feeling that the system adopted, even though it was said to be preliminary, did not go far enough in identifying the kind of operational information that they wanted in order to bring hospital managers to book. The system published by Burdett contained many suggestions for the kind of data that was felt to be necessary for effective analysis, but was not included in the form that the hospitals were required to return in order to attain a grant from the fund. While the adoption of the uniform accounts did appear to be a victory of sorts, the control that was sought by the reformers was still some way off.

The next chapter will discuss the discourses and events that led to the hospital reformers of the 19th century finally achieving, both the adoption and the necessary

authority that was required for their system of accounts to realise its potential. With the enlistment of key figures of authority and status, the reformers were able to use the *Uniform Accounts* not just to see where the major problems lay in the management of hospitals, but to force remedial action from the relevant managers.

6. THE KING'S FUND, UNIFORM ACCOUNTS AND A FRAMEWORK OF CONTROL

> "The perfect manager, like many a clever housewife, will have no direct control of the purse. Like such an one he may be lacking in power to draw a single cheque without reason shown, and must submit the result of his work in the minutest particulars of expenditure to those who grant the supplies. Yet, none the less, his is the eye which supervises the whole, and his is the hand to which all turn in the constantly recurring need in institution life of "getting things done." ... He never interferes in the usual sense of the word, for interference is but a symptom of partial knowledge. It is, in brief, his business to know just a little more about each department than those actually in charge." (BHC, 1898, p.203).

6.1 Introduction

The adoption of a uniform system of hospital accounts by the Metropolitan Hospital Sunday Fund in 1893 should, arguably, have been regarded as a triumph by the hospital reformers. Ostensibly at least, they had achieved their goal of persuading the majority, if not the totality, of London's hospitals to provide annual reports in a common form that would allow interested parties to analyse the accounts in order to make judgements regarding the economy and efficiency of the institutions concerned. However, despite the apparent success many had reservations. *The Lancet* was immediately concerned about the form of accounts, questioning their usefulness and offering suggestions for improvement. Additionally, the effectiveness of the Sunday Fund itself was called into question. Doubts were raised about the commitment of those leading the Fund to the cause of reform. Further doubts arose

over the ability of the Fund to actually influence the practices of hospital management. Even when the Fund did exhort hospital managers to behave in a certain way the recommendations were often ignored and the fund appeared powerless to enforce them. The problem was that although the reformers were increasingly gaining control over the information deemed necessary to make judgements about the management of the hospitals they still lacked an effective lever with which to persuade managers to adopt the practices they recommended. They had hoped that the grants awarded by the Sunday Fund would prove persuasive but as will be shown this mechanism was flawed in a key way and ultimately became redundant. Thus, while the adoption of the uniform system of accounts could be perceived as a significant step forward its impact on the cause of the reform and control of hospital management was limited.

This chapter will explore how these limitations became apparent and examine the process by which the reformers, led by the perennial Burdett, sought to create a more influential organisation, one which commanded the respect, not only of hospital managers, but of the charitable public. This organisation (which came to be known as the King's Fund), was able to influence hospital management much more effectively than the Sunday Fund by its more authoritative insistence on the adoption of the uniform accounts and its equally authoritative pronouncements based upon its analysis of these accounts. By this mechanism, the King's Fund was able to control and eliminate those practices of hospital management that were deemed to be unacceptable. In time the King's Fund was able to establish itself as

an authority on the management of hospitals to such an extent that it became, at first effectively, but ultimately officially, the central board of control for London's hospitals.

The chapter will proceed by first examining *The Lancet's* response to the particular form of uniform accounts adopted by the Sunday Fund. The next section will show how Burdett, perhaps frustrated by the apparent unwillingness of the Sunday Fund management to direct hospital management, seized upon the information generated by the uniform accounts and began to publish regular and detailed analyses of the data. His conclusions put pressure on the Board of the Sunday Fund to suggest changes to the management of hospitals. The chapter will then explore why this advice was typically ignored and why the Sunday Fund and other forms of central control were ineffectual. Discussion will then shift to the establishment of the King's Fund and the reasons why this particular organisation was able to establish authority where its predecessor had not. The chapter will conclude by examining how this new fund was able to use the uniform accounting system to promote what was perceived as good practice in the Metropolitan hospitals.

6.2 The Response to the Adoption of the Uniform System of Hospital Accounts by the Metropolitan Hospital Sunday Fund

It might have been expected that *The Lancet's* editor would have been delighted with the adoption of uniform system of hospital accounts by the Sunday Fund, but

Wakley was far from impressed with the initial response and soon made it clear that the issue was not now at rest. In an outspoken editorial he declared that it was 'a most disappointing result and one that augurs badly for the ultimate success of persuasive methods in improving the present modes of hospital administration' (July 16, 1892, p. 162). The reason for this outburst was not the fact of the adoption of the accounts by the Sunday Fund, but rather the limited extent of the implementation by the hospital secretaries. After the initial poor response to the attempt to persuade the managers of the hospitals to implement the system voluntarily, the editorial observed that:

> "it seems to us that they are equally ungracious and unwise–ungracious because the request was an eminently reasonable one, with which they might have complied at very little cost of trouble or inconvenience to themselves, and unwise because delay in a matter of this kind is much more likely to result and aggravated demand than in any event more agreeable to the hospital authorities. The importance of uniformity in the presentation of accounts is a thing which has been clearly apprehended by the public or that section of the public which busies itself with such discussions, and it is not at all likely to pass out of sight." (*The Lancet*, July 16, 1892, p. 162).

Bemoaning the fact that barely half a dozen hospitals had used the new form, it was further observed that at that stage the situation had become worse due to the Sunday Fund's form 'superadding a new type to those already in use' (p. 162) *The Lancet* relentlessly pursued the theme of universal compliance with the proposed system. While it was conceded that the complexity of hospital accounting was such that it could not at best 'be a really simple thing' the reader was reminded of the necessity for the council of the Sunday Fund to receive the information 'in a form which makes the comparison of various institutions as simple a matter as

such a thing can be' (p. 162). No information was likely to be requested that could not easily be supplied, especially as the form that had been put forward was that constructed by the committee of hospital secretaries set up for that purpose. This was a point grasped by *The Lancet* as it once again tried to influence the final structure of the system to be adopted by analysing what they perceived to be the shortcomings of the current proposal:

> "[The existing proposal's] shortcoming is that it follows so closely the old and accustomed lines that it does not convey the information which the public most desire and which it is necessary to bring clearly out in the interests of the hospitals themselves ... the fundamental considerations of perspicuity and completeness in the statement have been sacrificed in the preparation of this form to the subordinate consideration of what will cost least trouble to the officer charged with the preparation of the accounts, and yet even to the extent of adopting a form of statement modified so slightly from that with which they are familiar the secretaries for the most part have refused to accede to the request of their benefactors." (*The Lancet*, July 16, 1892, p. 162).

With this thrust the attack suddenly appears to have shifted to additional fronts. Not only were the hospitals accused of being unreasonable in not providing the requested form but the secretaries were accused of being doubly unreasonable by not producing a form of statement that *they* had ensured was minimally different from that which they were already preparing. The implication was that the secretaries committee were failing to take the process of uniformity seriously and were spoiling it by limited reform and delayed implementation.

Whether it was fair to launch such a vehement attack on the hospitals when the request from the council of the Sunday Fund had been advisory in 1892 is a moot point. What was demonstrated was the scepticism amongst at least a

section of the reform movement, about the quality and effectiveness of the reforms that were being made. Additionally, it does indicate that the hospitals were in no hurry to see their finances presented in a form that allowed comparison with other institutions. The reformers were stating that they were not about to be diverted by the apparent presence of gradual progress towards their goals; they had been on the trail of uniformity in accounts for decades and were keen to avoid an overly compromised solution that would, on the one hand, defuse the strength of their arguments and, on the other, substantially fail to deliver the information that they sought.

As to the motives of the hospital secretaries, it is unclear whether they deliberately refused to make their returns to the Sunday Fund using the uniform system, or, whether they felt that, because they were only advised to use the form in 1892, it wasn't of great importance. Nevertheless, their failure may have helped to prompt the council of the Sunday Fund to ratify full adoption in the following year. At this point the percentage of institutions adopting the uniform system in their applications to the fund increased dramatically. By 1894 therefore, for the first time, the reform movement had comparable (although limited), accounting information upon which more credible analyses of hospital management could be conducted. It took little time for the results of such deliberations to find their way into print and into the public view.

6.3 The Analyses of Henry Burdett

Burdett was amongst the first to seize upon the new information, collating the data collected by the MHSF and publishing extracts and analyses of it in his series *Burdett's Hospitals and Charities of the World* (BHC)[1]. Of course Burdett suffered a significant lag in the production of his volumes. Thus, the volume that contained the first significant uniform data, from 1894, was not published until late in 1895. This lag required him to reflect on the issues of the year of data collection as well as those of the year of publication that might then have been influencing management responses to significant issues.

Burdett's style was typically combative and dramatic. He would immediately create an impact by aggregating all the income of British charitable institutions (insofar as the data was within his grasp), pointing out that the sum of money involved in 1894 was a 'total charitable revenue of nearly seven and a half million pounds' (BHC, 1895, p.51), a figure that must have seemed amazing to the Victorians. He then critiqued the focus of London's charitable public by observing that

[1] Burdett had produced the series from 1890-93 as *Burdett's Hospital Annual* and changed the name to *Burdett's Hospital's and Charities of the World (being the yearbook of philanthropy)* and published it on an annual basis. Its publication continued until 1930, 10 years after the death of Burdett. The volume of data collated within each issue was staggering. It contained extensive tables of data showing the reported income and expenditure primarily of hospitals, as well as data collected from other charitable organisations such as schools, religious missions and welfare bodies, for example. The data in the tables was contextualised and analysed in depth with summaries of the primary issues presented in a chapter at the front of the volume. While many forms of charity were discussed in the series there is no doubt that its main focus was on the hospitals of the UK, with the vast majority of the data and analysis space given over to issues relating to these organisations. Furthermore, it is easy to discern, by the amount of space dedicated to it, that within the set of British hospital data included in the series it was the voluntary hospitals that attracted most of Burdett's attention.

while £2,460,000 had been received by home and foreign missions based in London, only £790,000 had been given to the 102 general and special London hospitals, subsequently highlighting the 'extravagance of the management of some of these missionary societies', alongside the apparent indifference of the public to the sick and dying at home (BHC, 1895, p.51). This reinforces the idea that Burdett always regarded himself as a friend of the voluntary hospital movement; his concerns were never with the principle of voluntarism or with the merits of the hospitals' activities (which he lauded), but rather with the methods of management deployed within the institutions. It seems unlikely, however, that the managers of the London hospitals would believe, at this point, that they would escape the searchlight of Burdett's figures, and they certainly did not. Shortly after his demolition of the management of the foreign missions and armed with the uniform accounting data, he turned his attention to the London hospitals.

6.3.1 Burdett's Central Themes

Burdett's attack was on two broad fronts: firstly he criticised the form of expenditure made by the hospital management and then he worked at the average costs of the institutions' activities. Specifically, he charged the management of the London hospitals with committing funds to activities outside the normal operating parameters:

> "When legacies are included, the income of the thirty-eight general institutions in London exceeded the ordinary expenditure by about £66,000. This surplus was turned into a deficiency by the managers, who laid out upwards

> of £183,000 during 1894 upon objects outside the ordinary work of the institutions. That is to say, they increased the ordinary expenditure to a sum equal to 39 per cent., and so brought about a deficiency in their accounts for the year of upwards of £117,000" (BHC, 1895, p.53).

Implying that this expenditure could not satisfactorily be justified, he said that it was 'a plain duty to point out that the extraordinary expenditure in London is appreciably greater than that of any other group of hospitals throughout the country'[2] (BHC, 1895, p. 53). Contrasting the 39% of extraordinary expenditure seen at the London general hospitals with that of the 8% seen at the provincial general hospitals and constructing a similar case for the special hospitals, Burdett argued that the management of the provincial hospitals was 'immeasurably more careful and business like' (BHC, 1895, p.54). He deplored the way in which hospital managers would spend large sums without knowing where the money would subsequently come from, insisting that such projects should be restrained until funding was in place.

The second front concerned the cost of service provision in the capital. He observed that the number of beds per 1000 of the population was substantially higher in London (2.18) than it was in the rest of England and Wales (0.81), or elsewhere in the United Kingdom, but that there was no sign that this brought any efficiency of operation. In fact, the cost per bed in London (even with the exclusion of extraordinary expenditure) was far higher at £76 and £79, for the general and

[2] Of course the primary target of this argument was the continuing tendency for hospitals to spend any large legacies in order to ensure that the year end accounts showed a deficit, which was held to be essential for fundraising.

special hospitals respectively, than it was for the provincial hospitals at £44 13s. and £45 11s. respectively. Scottish and Irish hospital beds were also shown to be much less expensive in comparison to London.

Together these arguments were damning to the management of the London hospitals. They were on the one hand accused of being profligate and irresponsible and on the other, inefficient and incompetent. There was a general call to hospital managers to provide 'explanation and comments upon these points in the interests of sound hospital administration' (BHC, 1895, p.54).

In modern terms there can be no doubt that Burdett's figures were crude and took no account of quality or of local circumstances was taken, but in late Victorian England the arguments he was making were powerful. To the lay person, there would probably be little understanding other than that the sick poor were getting treated at a much higher cost in the capital than they were elsewhere and this would, to the typical Victorian mind, seem unjustifiable. Nevertheless, Burdett was aware of the shortcomings of his data and constantly berated institutions that refused to adopt the uniform system of accounts and praised and encouraged those that did, or those that indicated that they might.

It might be thought that the constant attacks on hospital management were risky for Burdett. He was not, after all, a person of rank, nor was he wealthy, and many people involved in the management of the hospitals were arguably of higher social standing and, given their numbers, in a powerful position to respond

and damage his career. But Burdett was an extraordinary man with a tremendous capacity for work which he applied to create prodigious output. His ability to marshal vast quantities of data had made him a formidable opponent and his stamina in an argument seemed second to none. Thus even in the mid-1890s, fully a quarter of a century before his death, he was treated with the greatest of respect by his opponents. When he made a transposition error in his figures during the preparation of a letter to *The Times*, which led him to attack hospital management more severely than was justified (*The Times*, 27th December, 1894) he published a correction to the transposition a week later (*The Times*, 3rd January, 1895), but refused to moderate his conclusions. The frustrated response from Burford Rawlings could be hardly more critical than to say, 'It would be absurd to question Mr. Burdett's comprehensive grasp of his subject, yet it may be permitted to us to inquire whether he is not getting a little out of touch with the actual daily work of the hospitals and a little more dependent upon statistics'[3] (*The Times*, 9th January, 1895). Rawlings was only too aware of the force of Burdett's pen in the press and probably feared the response, but his tact paid off and when Burdett published his response he was civil, but demolished Rawlings' arguments nonetheless (*The Times*, 15th January, 1895). In particular he took exception to Rawlings' suggestion that he was out of touch with hospital management and over-reliant on statistics. However rather than deny his own over-reliance on statistics,

[3] Rawlings was the Secretary of National Hospital for Paralysis and Epilepsy, one of the London special hospitals, and his nervousness at broaching Burdett's error was clear when he started his letter: 'I have been hoping that some more powerful pen than mine would be exercised in reference to the two letters from Mr, Henry C. Burdett which recently appeared in your columns'.

Burdett argued that they gave him 'means of observation and judgement which no one actively, but solely engaged in a single institution can acquire' (*The Times*, 3rd January, 1895, p. 3).

This was typical of the claims made by those that had the comparative data generated by the uniform accounts at their command. The ability to aggregate the data and calculate averages was held to be definitive in its ability to show those institutions that were exceeding the norm. In promoting these ideas Burdett was both tireless and relentless, carrying on his campaign through his own publications such as the annual *Hospitals and Charities of the World* and the fortnightly *The Hospital*, as well as a range of other media such as *The Lancet* (whose editorials continued to support the cause of reform), *The Times*, and any other journal that was prepared to host his debates. But as has been said in chapter 5, Burdett and the editor of *The Lancet* were not the only people concerned with the reform of hospitals; the general practitioners continued to be incensed by the continuing practice they called hospital abuse.

6.4 The Struggle for Action

In a separate campaign in the mainstream and medical press general practitioners constantly lobbied against the use of free hospital outpatient clinics by people that they felt could afford to pay for the services of a doctor. Although we must question the value of the service that was provided it is clear that increasing numbers of peo-

ple were using it. Understandably, GPs were upset that potential paying patients were passing their doors and going to the hospitals instead. The loss of income was probably significant; although it is not clear how many patients the GPs were actually losing. Some people may have sought hospital treatment simply because it was free and would not necessarily have paid for a consultation. However, the out-patient clinics were not pleasant, invariably involving long waits amongst the very poor and sick with only cursory treatment as a reward, so it may reasonably be assumed that the populace would not lightly undertake such a visit. In any case, whatever the reality, the GPs believed that they were losing income and their campaign was pursued with vigour. This lent significant additional persistent weight to the argument that hospital management was in need of reform although it did not always lend focus towards a solution and there was more than one proposal to consider.

Throughout the 1890s there was debate over whether or not there should be a formal central board of control over the activities of the hospitals. The idea was floated initially by Charles Loch, then Secretary (since 1874) of the Charity Organisation Society. The COSs belief that unguided charity was extremely damaging to the nation was behind its primary principle that charity should be organised and governed and it constantly argued for effective control of charities amongst which the hospitals were an important group[4]. This proposal was considered seriously

[4] The COS was not universally highly regarded. Many felt that it sought too tight a control over the charities and others felt that its constant criticism simply led to the public withdrawing their support. It is hard to see that the COS regarded withdrawal of support as a bad thing. Its leaders genuinely seemed to feel that if charity could not be directed in a way that would

by many and was the subject of an extensive and well regarded Select Committee enquiry from 1890-1892 (SCMH, 1892), which in a four volume report concluded that the problems created by the lack of organisation of the hospitals were both very significant and largely neglected:

> "...so far from there being at the present time any general system of combination or any definite division of work among the various institutions they are on the contrary for the most part competing with one another at every point for public support, and to a great extent for patients. This condition of things is wasteful and prejudicial to the sick for whom these institutions exist and to the interests of medical science and education. The evils of the present system, or want of system, are generally admitted but little has been done hitherto to cure them" (SCMH, 1892).

The Select Committee report agreed with the proposal of the COS for a central committee stating that the idea was worthy and should be implemented. However, the form could not be agreed upon and the debate stretched over a number of years. *The Lancet* quickly observed that it had felt 'since the publication of the Lord's Report that it dealt too weakly with some acknowledged evils and abuses of administration' (28th January, 1893). Governmental involvement remained unacceptable to most, as there was a general lack of trust in the competence of the state to administer anything efficiently and any provision of government funds was likely to be detrimental to the ability to raise donations (Abel-Smith, 1964: Rivett, 1986). The Charity Organisation Society as an alternative to the state as the force behind a central board was no more popular with many. Burdett observed that 'it is quite certain that neither the public nor the hospital authorities will consent

discourage dependence, then it had no place in a well managed society.

to the establishment of a Charity Organisation Central Hospital Board for London or for the country' (BHC, 1896, p.103). He also critcised the desired general conditions of the central board proposed by the Lord's Committee that the COS published in a circular as 'but a rehash of those which have found expression on previous discussions on the subject' (BHC, 1896, p.102). For instance, at a meeting of the COS on the 25th January 1897 it was stated that the board ... 'should have no compulsory powers, but should simply influence the public and the Hospitals by the issue of an annual reports giving information as far as possible in a comparative form on various crucial questions connected with their administration' (*The Lancet*, 30th January, 1897, pp.336-8). Burdett's response was not an attack on the proposal itself, but on the failure to reflect that the:

> "duties of the Board, as proposed by the Lord's Committee, have been largely adopted by the Hospital Sunday Fund ... The Hospital Sunday Fund, for example, publishes an annual report and issues tables of statistics which cover much of the ground suggested by the Lord's Committee. The whole of the accounts of the metropolitan hospitals, properly so-called, are now audited by competent chartered accountants and they are kept upon the Uniform System" (BHC, 1896, pp.103-4)

Defending his (and *The Lancet's*) favoured scheme, he argued that a proposal mooted at the Hospital's Association that the Council of the MHSF should be enlarged to enable them to elect 'an Executive Central Hospital Board in the form of a Distribution Committee' was perhaps the best way forward, although he did acknowledge the 'animated discussion' that this had initiated in *The Hospital* (2nd, 9th, 16th, 30th May, 1896). Ultimately, however, the plan for a central board of control acting on the basis of the information generated by the uniform accounts

floundered at this point as the various bodies with interests in the affair all tried to take measures independently with the result that no real progress was made. The debates surrounding the concept of a central board ran parallel to those of the hospital funds and both drew on broadly the same sources when it came to citing problems. Ultimately, it was the failure to implement a central board that threw the emphasis back onto the hospital funds and to efforts to promote management reform through leverage created by the funds' ability to award grants.

The reformers continued to be disappointed though. By the mid 1890s the Sunday Fund arguably had, by means of the Uniform Accounting System, the informational ammunition it required to make pronouncements on the efficacy, or otherwise of the hospitals' management. Whether the accounts could really reveal much about the management practices of the hospitals remains questionable, but what the uniform system did was to disable the defence previously used by the hospitals that the hospitals' accounts were all prepared in different ways and so could not be used for comparison. Now, supported by Burdett's analyses and publications, it was easy for the Funds' management to view significant exceptions from the mean performance of hospitals, whether that be in terms of income, expenditure, costs, or output. The onus was now potentially on the hospital management to explain the exception if they wanted a grant and if they could not explain it, or if they did not agree to amend the offending practice, then the grant could be withheld.

Some have argued that the grants were not of sufficient scale to persuade hospital management to reform (Millman, 1974), but although the grants were a fraction of total income they could also be the difference between serious deficit and minor deficit. They were also fairly easy money; much less trouble than pursuing recalcitrant subscribers. Another, arguably more significant, reason why the grants were important was their ability to signal to the charitable public that the institution was meritorious and well managed. No one wished to donate charity where it would be squandered and the allocation of a grant from a body such as the Sunday Fund, one of whose criteria of award was to scrutinise for sound management, was something of an endorsement. Unfortunately it soon became clear that whatever the evidence at its disposal, the Sunday Fund was extremely reluctant to insist on hospitals reforming their management practices. The disappointment that was felt about the Sunday Fund's unwillingness to fully engage with the reformist agenda before the late 1890s was displayed by *The Lancet* when it argued that the Sunday Fund could not be considered as a real central organising body unless it was to 'show some larger sense of responsibility that they had yet displayed' (*The Lancet*, 1st May, 1897, p. 1221). The Sunday Fund Distribution Committee were described as having been 'fearful' of taking the necessary action (19th February, 1898, p. 519).

The reason for this seems to be grounded in the arguments that surrounded the establishment of the Sunday Fund. At the first meeting of the MHSF Council there had been an attempt by a prominent member of the COS, Sir Charles Trevelyan,

to propose that grants should be contingent upon anyone not able to prove that they were genuinely poor having to make payment for the services they received in the hospital. The rest of the council wished to distance themselves from this idea and from the attitudes of the COS in general. Sir Sidney Waterlow as Chairman observed that the council had been elected to 'aid the hospitals as they are now conducted' and Trevelyan's motion was defeated. It has been argued that Waterlow was subsequently reluctant to modify this attitude with respect to the hospitals' activities. Clearly if the chairman of the Council would not withhold grants to encourage better management then the potential of the accounts to make poor management visible was irrelevant. If the hospital managers were going to get the funds regardless of the perception of their management efficiency then there was no incentive for them to change.

It has also been argued that campaigners like Wakley and Waterlow had been required to give assurances to many individuals of a high social standing who were involved in the hospital movement that the activities of the fund would not interfere with their own fundraising and they may have also privately had to agree that grants would not be contingent upon the hospitals acquiescing to demands made by it. One documented example of this happened between Waterlow and the Duke of Westminster, who was the Treasurer of St. George's Hospital (Abel-Smith, 1964: Rivett, 1986). Clearly to renege subsequently on this promise to such a powerful individual would have done nothing for Waterlow's career and this was a likely factor in his non-intervention. In fact it may have been a general reluctance on the

part of Waterlow to upset the committees of hospitals, which often had such figures on them, that disarmed the potential power of the Sunday Fund. The problem was that the Fund was only as influential as the people on its council and Waterlow was arguably the most powerful of those. His social standing and influence was limited compared to that of the Victorian aristocracy which populated the boards of management of many of the hospitals.

In the end the primary achievement of the Sunday Fund, in the eyes of the reformers, might have been viewed as the adoption of the Uniform System of Accounts. Certainly the fund did raise money for hospitals which was its primary espoused aim, but it did little or nothing else for the reform of hospital management. It is possible that Waterlow's motives were altruistic and his judgement sound. Without the authority of a major patron of the highest social standing, the MHSF remained a fund of money raised mainly from the middle class and distributed mainly by the middle class. Indeed, those that sought increased status would hardly find it through association with the fund. Rather, they would seek appointment to the committee of management of one of the hospitals. Thus by the middle of the 1890s the Fund had remained relatively ineffectual in its attempts to use the new accounting information as a basis for management reform. Its leaders lacked the willingness to tackle hospital management head on as they simply lacked the authority and status to insist on the desired changes to management practice. In other words, while the accounting information had gained a credible and more or less unchallenged status, the entity that was publishing and making

pronouncements upon it had not.

6.5 The King's Fund: the Emergence of a Credible Authority in Hospital Management

6.5.1 The Establishment of the Prince of Wales (King's) Fund and the Significance of the Patron

By the second half of the 1890s it was becoming clear that the Sunday Fund was not going to be the force for reform that activists had hoped and some were clearly looking for an alternative. It was the ubiquitous Burdett who facilitated the solution and neatly outmaneuvered the COS at the same time. Acting on 'a fundamental truth about organised charity: it was not simply the nature of the campaign that determined its success, but who could be found to support it' (Prochaska, p. 11) Burdett found the ultimate supporter in the personage of the Prince of Wales[5], when in late 1896 the idea began to form in the shape of a new fundraising body for the hospitals. As soon as the idea was mooted there was a general clamour of approval, but simultaneously debate broke out over the form and purposes of the Fund. All wanted to be involved and each party wanted to impress their own agenda upon the structure. To his credit, Prince Edward seems to have listened to all, but ultimately firmly steered the new organisation onto a clear and unambiguous path of a body designed to raise significant sums of money that could

[5] Burdett was instrumental in bringing the Prince of Wales into the arena of hospital management although he avoided any claim of involvement. He had already managed to recruit the Prince and Princess as Patrons of the Royal National Pension Fund for Nurses in 1889 and had written a flattering book about their philanthropic activities (Burdett, 1889) in the same year (Prochaska, 1991). Prochaska argues that Burdett had been nursing the scheme for as much as a decade and certainly by 1896 he was a trusted advisor to the Prince and, as Rivett (1986) has argued, the emergent scheme was redolent of his long established and promoted ideas.

be allocated to the hospitals along with 'advice' on how their management should be conducted[6]. The first meeting of the general committee of the Prince of Wales Fund (PWF) took place on January 21st 1897 at Marlborough House in London. Burdett quickly became a member of the organisation committee and was central to the establishment of the PWF in the early months of 1897.

On the face of it this may seem to have been just another attempt at fundraising for the hospitals, but the new Fund had an extra dimension that would transcend its predecessors. As Prochaska (1991, p. 12) wrote: 'both the presence and capacities of Edward, first as Prince of Wales and then as King, had a near-mystical significance when brought to bear on the charitable establishment[7]. Further, the involvement of the Prince led to him persuading the great and the good to become members of the Council and administration of the fund. Lord Rothschild was the Treasurer and the Council included such figures as the Governor of the Bank of England, the Presidents of the Royal Colleges and the Bishop of London. Lord Lister, the founder and great disseminator of antiseptic medicine and arguably the nation's most prominent medical man at that time, was made the Chairman of the Distribution Committee. Through this approach the Fund was given enormous status and authority, which was reinforced in the year of its commission by linking

[6] It is quite difficult to find, in the final constitution of the Fund, any ideas that conflict with those of Burdett

[7] It has been argued that the Royal family saw their involvement in philanthropy as a means of legitimation after the gradual withdrawal of Queen Victoria from political life. However, Prochaska further argues that historians, 'ensnared in a conventional view of politics, ... ignore the influence that the royal family exercised through the voluntary movement' (Prochaska 1991, p. 12).

it to national celebrations surrounding the Diamond Jubilee of the Queen in 1897.

It is still the case today that charities seek prominent celebrities as backers and at the end of the 19th Century in Britain, there were none more prominent than the royal family. At that time it was still in the memory of the populace that the Monarch had been heavily involved in the politics of the Nation and the decline of that involvement that had taken place as Victoria aged had begun to be replaced by a much greater social involvement by the younger members of the family through philanthropic engagement. The significant involvement of the Prince of Wales in this and other charities reinforced his standing and positive public image and in turn this increased his authority at the head of the fund. It was this authority that gave the Prince of Wales Fund (PWF) its real power. Certainly it was to generate more in donations than either the Saturday or Sunday Funds, but also, the people involved in the day-to-day management of the Fund could not be as concerned about upsetting powerful individuals elsewhere when their own ranks were of the highest status. Burdett was adamant that there was ample evidence to show that 'business methods may be applied to hospital finance by persons of authority and influence with the best results' (BHC, 1896, p. 56). This situation was further reinforced when on the death of the Queen in 1901, Edward became King and the name of the fund was changed to the King's Fund (KF). Whilst the King stepped down as chairman, the new Prince of Wales took over and the King retained an enduring interest in the activities of the fund. The highest echelons of the royal family were more than just figureheads for the fund, they were an

active presence in its management and this dramatically increased its status and authority (Abel-Smith; 1964, Rivett, 1986; Prochaska, 1991).

6.5.2 Uniform Accounts and the Prince of Wales Fund

The Lancet was quick to praise the involvement of the Prince, but like the COS they had not quite grasped the long term significance of it. The journal argued that the PWF should be strictly time limited so as not to interfere with the activities of the other funds (Feb 13th, 1897, p. 462). Nevertheless they saw the potential to use the PWF to reinforce and further their general aims of reform. While lauding the three primary reasons for the creation of the fund stated in an open letter released by the Prince[8] *The Lancet* argued that there was a fourth reason:

> "which has grown in force rapidly of late and which must be met if the scheme of the Prince is to be worthy of his Patronage and of the reign for which it is to be the chief metropolitan thank offering. We refer to the laxness of hospital administration and the failure of hospital authorities from their splendid and benificent work all pauperising influences and all superfluous charity ... the General Council may be slightly enlarged by the addition of those who would represent the strong desire to see a magnificent relief of the impecuniosity of London hospitals accompanied with a guarantee that necessary reforms of administration shall be a condition of receiving a share in the Prince of Wales's hospital Fund for London" (*The Lancet* 13th February, 1897, p.462).

But they need have had little fear; it quickly became clear that the PWF was not simply to be a body that would uncritically distribute cash to those hospitals that claimed a deficit and the uniform system of accounts was to play a central

[8] The letter offered that the main reasons that only around 10% of those that could donate, did donate, was because: it was difficult to know which institution to give to; there was no easy annual opportunity to make a donation; and there was a sense that giving a small sum made little difference (*The Lancet* Feb 13th, 1897, p.462)

role in the examination of hospital administration that was to follow its inception. *The Hospital* maintained the debate by arguing that:

> "it is clear that that by the exercise of careful judgement in the distribution of such funds an influence for good may be constantly brought to bear upon [the hospitals] administration. These are reasons which may properly be urged in favour of the intervention of the great collecting organisations between the subscribers and the hospitals" (*The Hospital* 25th September, 1897).

In this it was made clear that the desire was to use the funds to influence the opinion of subscribers. The implication was that the proclamations of the funds, including the PWF, would enable the subscribing public to make judgements as to which of the hospitals were worthy of their donations. Thus the power of the funds lay not just in their own ability to withhold monies from particular hospitals, but to persuade a significant proportion of the charitable public that they also should direct their philanthropy elsewhere. This effect would leverage any action taken by the funds and put far more pressure on hospital management to comply with the wishes of the distribution committees of the funds. Any thoughts that there may be competition between, or conflicting instructions coming out of different funds were soothed by the decision of the PWF to look to the Distribution Committee of the Sunday Fund for its first year's distribution, until it was in a position to collect the necessary information on its own behalf. Also, Burdett had neatly manoeuvered the Prince into the position of Vice-Patron of the Sunday Fund in late 1896, which significantly boosted that fund and created an alignment between the two funds that arguably strengthened the authority of the Sunday Fund, although it immediately had an impact on the funds collected by the elder body and it

was to become clear in the longer run that it had really been superseded by the PWF/KF. Certainly in 1897 the pronouncements of the Sunday Fund had a more authoritative voice as they acted 'even more stringently on the rules laid down for their guidance'[9] (*The Hospital* 14th August, 1897, p. 342) and there was a renewed emphasis on the:

> 'tables of statistics ... showing an analysis of the number of beds, the cost of patients ... [and] the proportionate expense of management, as well as other valuable information. ... The work was much facilitated by the fact that the accounts are rendered on the uniform system." (*The Hospital* Aug. 14th, 1897, p. 344)

In promoting the work of the Distribution Committee *The Hospital* further emphasised the centrality of the information collected through the uniform system of accounts:

> 'As a preliminary to [the distribution committee's] meetings, nearly four months are devoted to a careful examination of the accounts of nearly two hundred institutions, which apply for grants. When the analyses of these accounts are ready the Distribution Committee commences to sit. They then go through the accounts of the expenditure and work done by each institution, and pay particular attention to the quality of the management, the economy of the administration, and the merits and pecuniary needs of all the charities concerned" (*The Hospital* 14th August, 1897, p. 329).

Thus the uniform accounts were the key factor that allowed the fund to make its judgements with authority. Since the adoption of the uniform accounts, complaints in the press that the judgements made on the economy and effectiveness of hospital management were unfair on the basis of the information held by those making

[9] The distribution committee had insisted upon hearing from deputations of no less than 38 hospitals who were asked to explain either the manner in which funds had been expended, or what was perceived to be extravagant management. (*The Lancet* 13th February, 1897, p.462)

the judgements became very muted. Instead the arguments of those defending a hospital's management tended to focus more on any special circumstances that had assailed the management in the period concerned; the comparative data remained generally unchallenged by those outside the funds. This is almost certainly because Burdett had long been sensitive to criticisms of his accounting and was never content to accept that there may be irresolvable issues. Those that tried to defend against his conclusions in BHC by questioning his calculations typically got a thoroughly worked response:

> "Much criticism has been evoked by the examination of the expenditure on the administration of a hospital on the basis of comparison of the cost of administration with that of maintenance. Critics have urged that the only true basis is the percentage the cost of administration is of total expenditure ; and with a view to ascertaining whether there was any point or force in this criticism, we took the trouble to work out the cost on the critics' basis. We found that it made a difference on an average of less than two percent., and that in but very few cases did it make a difference of three per cent. We have included both calculations in the tables that follow so that any one interested may be able to compare the cost of administration in a given institution upon either of the two bases as he may think best" (BHC, 1897, p. 93)

What mattered to Burdett it seems was not his choice of measure, or the construction of his system, so much as the confidence that people had in the numbers that were produced. He worked tirelessly to eliminate questions that were raised over the statements and reports to the point that few continued to question them, other than on trivial points of detail. Nevertheless, there was cognisance within the management of the PWF that the accounts were not flawless and that they were not as useful as they might be. For instance, the ability of hospital managers

to list items under differing headings meant that comparability across institutions was not as good as it might be. With respect to this point, there can be little doubt that Burdett was also cognisant of it and regarded it as a matter of importance; he had long argued that 'there is no item of hospital expenditure so small as not to be worthy of the closest attention' BHC, 1897, p. 204). Therefore, fairly soon after its Distribution Committee met to begin work the PWF began to consider revisions to the uniform system of accounts. In 1901 the PWF had become the King's Fund after the death of the Queen and Edward's accession to the throne, and the committee at that point set up a team to revise the uniform accounting system (Gilbert, 1977, p. 62).

This was the first of a series of revisions that took place over a twenty year period. After the 1st committee's work was completed, Burdett published a revised volume of *The Uniform System of Accounts, Audit and Tenders for Hospitals and Institutions* (Burdett, 1903) and again after a further revision in 1916 (Burdett, 1916). Thus, from the last years of the 19th Century through the early years of the 20th, Burdett and others in the King's Fund, regularly reviewed and refined the uniform system in order to increase its effectiveness not just as a means of attaining accountability from the managements of the London hospitals, but in order to control them and assist them, in turn, to improve their management of the hospitals. Each of these revisions was adopted, in turn, by the MHSF and so, while ostensibly separate, the funds through much shared leadership and operational practice and attitude acted as a twin force in the cause of reform of

hospital management.

6.6 The King's Fund, the Uniform Accounting System and the Control of the Hospitals

On the basis of the recommendations of the MHSF the first distribution of the PWF was made'[10], more or less pro-rata with the MHSF, but with 'adjustments' made by a special committee. It is to be noted that the PWF envisaged itself to be a long term undertaking. The Prince himself proclaimed that the distribution made should come only from the income of the fund and not from the capital; a model that he espoused as being one upon which all voluntary organisations should settle (*The Hospital*, 25th December, 1897, p. 231). In addition it was felt that this endowment model would both create an enduring memorial for the Queen and increase the authority of the Fund over the London hospitals (Prochaska, 1991, pp.22-3). Setting the tone for the future Distribution Committee of the PWF, the Prince also stated that 'searching enquiries should be made into all matters concerning each hospital, so that all the amounts spent may be wisely administered. ...It is ...extravagance in the maintenance of hospitals which this fund should endeavour to discourage'[11].

[10] In the first year the fund raised some £155,000 in capital and £22,000 in income from interest and annual subscriptions, Alongside this was an amount of some £40,000 raised by the sale of special stamps for the Jubilee of the Queen which was also to be distributed that year. (*The Hospital*, 25th December, 1897, p. 230).

[11] The Prince gave as an example of maladministration the practice of hospitals that found themselves in possession of large legacies of building new wards, or large extensions onto the hospital, the typical outcome of which was that in the next financial year the hospital had insufficient funds to maintain the new facilities and was forced to close them down. (*The Hospital*, 25th December, 1897, p. 231).

The Lancet moved squarely behind the PWF, despite expressing some concerns as to how it may affect existing arrangements, and applauded the Prince for choosing the Sunday Fund as a model for distribution in the Fund's first year. *The Lancet* tried to reinvigorate the Sunday Fund and increase the pressure on hospitals across several fronts. Describing the Sunday Fund as a 'disciplinary body as well as a charitable body' that put 'a premium upon good management and economy' while 'rigidly exacting that all hospital accounts shall be rendered for their inspection in accordance with a uniform plan' it was argued that in 1897 the Sunday Fund enjoyed 'remarkable power' through the association with the PWF and that they would 'be able to discriminate in a marked manner between the deserving and undeserving institutions' (*The Lancet*, 12th June, 1897, pp. 1636-37).

By 1898 the proactive nature of the PWF was beginning to emerge. At a meeting of its council in February 1898 it was moved that there should be a committee of enquiry to examine the 'needs and merits for the allocation of the funds of 1898' (*The Lancet*, 19th February, 1898, p. 519). The Prince took up this resolution, saying:

> "[it is] perhaps the most important matter ... it will take time, of course, but I do not think it possible for us to keep to our original idea, –i.e., *to assist the most deserving hospitals only–unless it is made quite clear to us which hospitals are deserving and which are managed in a proper way*" (*The Lancet*, 19th February, 1898, p. 329)

The committee was duly formed and carried out its investigations throughout the course of the year (*The Lancet*, 10th December, 1898, p. 1569). The committee consisted of 'physicians and surgeons, of wide experience, and about an

equal number of laymen specially interested in hospital management' (*The Hospital*, 24th December, 1898, p. 221). All the hospitals were 'submitted to a thorough inspection and inquiry' with the forthcoming 'reports and tabulations' providing the most 'valuable and reliable information' (p. 221). The activities of the Distribution Committee soon met with the approval of Burdett. The committee he argued 'does not merely give to the hardest beggar', instead it used 'judgement and inquiry' which could not be achieved by the individual and exercised a 'wholesome control over the activities of some hospital managers' (*The Hospital*, 30th December, 1899, p. 205). Thus, the PWF, (and also increasingly the Sunday Fund, although it was always more tactful than the PWF), began to flex its muscles and put pressure on practices of hospital management that were deemed inappropriate.

This approach attracted much public support. It soon became clear that the PWF was attracting funding from bodies that previously had not supported the hospitals in an open or substantive way[12]. It was the increased confidence in the proper use of the funding that the PWF was generating that began to attract the donations of the public in various guises. Of course increased funding only increased the leverage that the PWF could apply to the hospitals. The medical and national press hailed the success of the first year of the Fund and very quickly there were clear cases of intervention in the day to day running of hospitals, based

[12] For example, the Worshipful Company of Drapers began to send an annual donation of £1000 to the PWF upon learning 'with much satisfaction that the committee have appointed visiting sub-committees consisting of persons practically acquainted with hospital management with the object of obtaining information as to the merits and needs of the various institutions' (*The Lancet*, 25th August, 1900, p. 593).

on comparative data coming from the accounts, that changed their practices in ways that were both empowering and controlling.

In general the funds, especially the PWF/KF, were very blunt about the reasons for refusing a grant. While conceding that the task of deciding which hospitals should be left out of the grant allocation was a thankless one, *The Hospital* argued that 'it is satisfactory to see that the committee [of the PWF] have found it practicable to lay down conditions with their gifts and to give reasons for their refusals' (13th December, 1899, p.205). The results of the deliberations of the distribution committees of both the PWF and the Sunday Fund were announced at their annual meetings, the proceedings of which were published widely in the press. Full, verbatim accounts were published in *The Hospital* and the *The Lancet*, while abstracts of the decisions were published in many other places including the *British Medical Journal* and national papers such as *The Times*. As a result the pronouncements of the committees that some institutions were 'by reason of their management, ruled to be undeserving of support' reached a wide audience (*The Hospital*, 7th January, 1899, p. 251). The potential subscriber, seeking the best place to make a donation had little work to do to establish which institutions were held to be inefficient or extravagant users of charity and therefore to be avoided. Hospital managers soon realised that to fail to secure a grant could strike at their funding in other ways. To ignore the funds was to risk existing subscribers taking the view that the hospital was badly run and withdrawing their support as well. So the grants and reports of the funds became much more important than their simple monetary value alone

would suggest. In any case the funds had aligned themselves very closely and to contravene the directives of one was to risk losing the grants of both, (and possibly even the Saturday Fund as well). In 1902 Prince George[13] noted that the work of the funds was 'in perfect harmony' (*The Lancet*, 13th December, 1902, p. 1648).

The information in the funds' reports was given further weight because of its provenance. Few had any questions as to the reliability of the information collected by the funds through the uniform accounting system and it was often the recipient of glowing praise. In 1903 *The Lancet* said:

> "It is hardly necessary to refer to the admirable effect which the introduction of a simple and universal system of accounts has had in London. It has, in particular, rendered possible the working of the Hospital Sunday Fund, which, in order to be able to test efficiency, has exacted uniformity from the hospitals to which it has made distribution and has thus paved the way for the effective working of the other great funds the committees of which have followed in its footsteps" (*The Lancet*, 19th February, 1898, p. 329).

Almost as few had anything to say about the judgement of those that made the decisions. The involvement of the highest stratum of society in the PWF/KF and, to a lesser extent, the Sunday Fund ensured that any questioning of the decisions was couched in the politest and most deferential terms. Responses from the PWF/KF, in particular, tended to be final and silence any further debate. The Sunday Fund, also tended to gain credibility through the parallels in the decisions between it and the PWF/KF. Although there were slightly differing targets for the money[14] the institutions identified as having poor management were much the

[13] Successor to Edward as the Prince of Wales and later King George V.

[14] The PWF/KF particularly targeted the redevelopment of infrastructure in the early years,

same in both cases[15]. Thus a culture of acceptance of the judgements of the PWF and the Sunday Fund emerged, both from the public and the hospital managers. Almost invariably the directions and recommendations of the funds came to be taken up by hospital management. It was exceedingly rare when a hospital had been given a conditional grant, or refused a grant, to see a repeated condition, or refusal in subsequent annual reports[16]. Compliance was very high indeed and increased as the funds became more established in their work.

An annual meeting of the King's Fund in 1903 became quite self-congratulatory of the success of the fund in its endeavors to create more efficient management. The Lord Mayor expounded that:

> "The good work that is being done by this fund it is quite impossible to overrate. The control over the management of the various hospitals, in seeing that they prepare their accounts in a proper form and that the money is not unduly wasted, is as great and as good a work as the distribution of the money itself. ... It gives the necessary *imprimatur* to those institutions who gain their support in appeals that they make to the public, and what is almost of equal consequence, it stops the stream of charity flowing to institutions which cannot prove to the satisfaction of the very able managers of this Fund that they are deserving of support from the public" (*The Hospital*, 28th February, 1903, p. 377).

The Prince of Wales was in full agreement, arguing that is was now clear that

with the reopening of closed wards and improvement of existing facilities a clear priority. However, the re-opening of beds usually came with a significant condition; i.e. that the beds had to be free and available to patients according to need and irrespective of the possession of a subscribers letter. Thus the KF began to erode the old system of patronage and move the hospitals towards a fairer provision of treatment according to need (E.g., *The Lancet*, Dec. 13th, 1902, p. 1647). The MHSF on the other hand tended more towards the provision of maintenance grants to those institutions that had insufficient income. Either way, securing a grant was important to the hospitals.

[15] Not terribly surprising when viewed in the light of the similar aims and composition of distribution committees of both funds.

[16] There were ocassions where grants were made on ongoing conditions, such as the re-opening of wards. In these cases, the money was granted conditional on it being used for that purpose and subsequent grants could be made on 'the same conditions as last year'.

the British public were quite prepared to support the hospitals to the necessary extent 'provided that they receive clear proof that the money is well spent' (p. 378). It was also, observed the Prince, good to see that the other hospital funds were basing 'their policy upon similar lines and are working side by side with us with simultaneous success' (p. 378). Lord Strathcona concurred, saying 'it is not the actual grant given to each hospital that is valuable, so much as the fact that the grant is only given after a thorough examination' (p. 378). Acknowledging the 'great and good work' done by the hospitals he added that 'it has not been found that they have been all equally perfect at all times', but that as it was widely known that the Fund's resources were applied 'only to those who endeavour to conduct and administer the affairs of their hospitals in the best way' this must assist the management of the hospitals to become 'still more perfect' (p. 378). There was no dissent at the meeting, all apparently felt that the work of the Fund was having a significant effect on the quality of hospital management.

The kind of issues the funds paid attention to fell into two broad categories: there was the problems of maladministration and waste within individual hospitals, but also there were wider, more general problems that affected the hospital world. The individual problems were handled either by instructions given to the hospital in question and stated in the annual report, or simply by refusal of a grant if the problems were felt to be too serious for quick resolution, or if the management were apparently intransigent. For example, a typical selection of comments from the 'Details of Awards' are abstracted from the 1902 report of the Distribution

Committee of the King's Fund below:

> "...
>
> British Lying-in Hospital, Endell Street, St. Giles.–£800 donation : £200 to nurses home and call attention to high cost of same.
>
> Cancer Hospital, Fulham Road, Brompton.–£200 donation. An excellent institution.
>
> ...
>
> Evalina Hospital.–An excellent institution.
>
> ...
>
> Hospital for Women, Soho Square.–£250 annual to open 6 closed beds. £850 annual to open closed wards. Draw attention to reports of visitors, high cost of in- and out-patients, and to cubic space and superficial area necessary for beds. £400 donation to discharge existing debts.
>
> Hospital of St. Francis, New Kent Road.–No grant.
>
> ...
>
> National Dental Hospital.–No grant.
>
> ...
>
> Poplar Hospital.–The Committee view with satisfaction the excellent management, and trust that the closed ward may be opened by the hospital authorities.
>
> ...
>
> Queen's Jubilee Hospital, Richmond Road, Earl's Court.–No grant.
>
> ...
>
> St. John's Hospital for Diseases of the Skin, Leicester Square.–No grant.
>
> ...
>
> Western Opthalmic Hospital.–No grant. To be reconsidered when proper progress has been made towards collecting the rebuilding fund.
>
> ...
>
> West London Hospital.–£1,500 annual to maintain new beds opened. £1,000 donation to discharge existing debts. £1,000 donation for bathrooms and other sanitary improvements on the east side, conditional on the work being done.
>
> ..."

(*The Hospital*, 29th November, 1902, p. 150)

As can be seen the comments could be positive as well as negative and were clearly intended to direct the contributions of the public towards those institutions that the KF perceived to be worthy as well as in need. When minor reservations or conditions were held they were detailed. When the problems were major, they were not and the perfunctory 'No grant' was applied.

With perceptions of problems in the management of specific hospitals the funds had little trouble, the management of the hospitals that were singled out typically came into line quickly. With wider hospital problems the funds often had to mount substantial commissions of enquiry to establish the best course of action, but when a course was decided upon the funds applied their criteria without hesitation and expected the management teams to comply. This was not necessarily problematic as managers were sometimes pleased with the solutions that the funds came up with. On occasion the solution was one that could offer direct benefits to the institution concerned. What follows is an examination of how the funds tackled a number of issues surrounding the management of the hospitals.

6.6.1 Hospital Procurement

Arguably one of the most effective and popular interventions was that into the cost of hospital procurement. Drawing directly on the revisions to the accounts published in 1903, the funds were able to construct extremely detailed tabulations of

the average cost of provisions at all the London hospitals that applied for a grant[17]. By this means they looked at the payments above the mean cost[18] and calculated that the London hospitals were paying £40,000 per annum too much for their provisions. Again, using the mean cost, they communicated with those hospitals that were apparently paying too much and, giving them an item by item breakdown, suggested that they should renegotiate with their suppliers. Some hospital managers realised that the harm that came from a listing indicating overexpenditure could be neutralised and even be turned into copy that could potentially boost their image and reputation as efficient institutions. Danvers Powers, the Chairman of the National Hospital for the Paralysed and Epileptic (NHPE), published an article in *The Times* explaining the steps taken to implement the directive to reduce the cost of maintaining in-patients (18th March, 1905). The result, Power claimed, was an annual saving of £2,000, a saving that could be realised by the other 37 hospitals that had received similar communications, were they to apply the techniques of the NHPE. This effort was met by plaudits from *The Lancet* as being likely to 'act as an incentive to similar activity in other institutions' (25th

[17] By the early 20th Century the exceptions were few. The only major hospital to remain independent was St. Bartholomew's (Bart's), which still had enough income from its endowments to remain outside the influence of the funds. Even Bart's was ultimately to surrender, however, as by 1920 it too had a funding crisis.

[18] The funds, and Nightingale and Farr before them, always worked on the basis of mean figures. There was never any suggestion that they would use the lowest figure and always argued against its use. The primary argument there was that the lowest figure probably reflected undue parsimony (perhaps as a result of shortage of funds) and did not reflect best practice. The mean figure on the other hand reflected the average practice of what were, in general, held to be very well run institutions and was there fore reasonable. It is almost certainly also the case that the mean was less open to criticism than a much lower figure. There is no evidence, however, that the funds took cognisance of the effect arising from the inevitably reducing mean that would result from the hospitals renegotiating contracts for supply. It is likely that the suppliers found themselves at the sharp end of this information year after year.

March, 1905). In April *The Lancet* commented on the positive way in which hospital managers were responding to the funds. Citing the example of the NHPE it observed that 'instead of producing the indignant protests which it probably would have called forth only a few years ago, [the reduction in the grant] was speedily followed by a careful and painstaking inquiry ... and by reforms' (8th April, 1905). The next year it was claimed that they had saved the hospitals £20,000 overall. This figure was substantial as throughout the second half of the 1890s the overall annual deficit of the London hospitals was said to be £100,000. Thus 20% of this deficit was removed at a stroke, with the work on procurement.

6.6.2 The Control of the Funding of Medical Schools

A second issue that arose around the turn of the century was the funding of medical schools, which was drawn to the attention of the funds almost incidentally. At that time the anti-vivisection movement was in full swing and one of its main targets was the medical schools, the site, as they saw it, of much of the vivisection currently taking place. The anti-vivisectionists drew attention to the way in which money donated to some hospitals was being channeled through to the attached medical schools. This had become an issue because the medical schools which had been highly profitable enterprises for the doctors that ran them had been suffering falling student numbers due to the advent of increasing numbers of provincial medical schools. As a result a number of hospitals had begun to divert funds into the

schools. The problem was aired in the press[19] and in October 1904 the King's Fund initiated an inquiry with the following terms of reference and instruction:

> "To consider and report–
>
> 1. Whether any, and if any how much, money given or subscribed for the relief of the sick poor to the 12 London hospitals having medical schools is contributed, directly or indirectly, by those hospitals, or any of them, for the maintenance of medical education.
> 2. Whether any direct or indirect return for such contributions (if any) is received by the hospitals from their medical schools and if so whether such return is equivalent to the amount of the contributions.
> 3. Whether, in the event of the committee finding that any hospital contributes to its medical school a sum in excess of the return it receives from its medical school, there are any special considerations advanced in justification of such expenditure, or any general considerations which would apply to all hospitals having medical schools.
>
> It is an instruction to the committee to deal with the subject on the basis of the existing arrangements and to accept from the hospitals as existing arrangements any such as they may advise the committee will be in operation on Jan. 1st 1905. " (King's Fund Committee of Inquiry into the Funding of Medical Schools (KFCMS), 1905).

The committee reported that it had been effectively impossible to answer point one. The accounts of some of the hospitals and medical schools were so integrated as to make it impossible to clearly distinguish one from the other. Direct contribution had been identifiable, but indirect support was obscure and the issue was further occluded by the inability to identify what proportion of expense had been incurred by treatment and what had been incurred as a result of medical education. To overcome this they assumed that money used for treatment was hospital expense and not education expense. Even with this interpretation the committee struggled to separate the assets and activities of the hospitals and the schools and

[19] See for example: *The Hospital*, Apr. 23rd, 1898; *The Lancet*, Nov. 5th 1904; Feb 25th 1905.

observed that professional valuers would be required for many of the items under consideration. In the end they confined themselves to items where clear statements of fact could be established. What they decided was that there was no common practice amongst the hospitals. King's College and University College hospitals were held not to be contributing to their medical schools; with Guys and the Royal Free there was sufficient doubt that contributions took place; but in the cases of Charing Cross, The London, The Middlesex, St. Bartholomew's, St. George's, St. Mary's, St. Thomas's and the Westminster 'contributions, either direct or indirect, or both, were made in the year 1903, to the schools out of the funds of the hospitals' (KFCMS, 1905). In addition to the contributions the committee found that:

> "the evidence before us, together with a study of the accounts, has brought too our attention remarkable variations in the expenses incurred by the several hospitals, and raises the important question whether, in the case of some of the hospitals to which schools are attached, there is not considerable extravagance and waste in the expenditure." (KFCMS, 1905)

They argued that this may have something to do with the way the institutions were organised as 'in such cases ... the real administration of the hospital will be placed mainly under the control of the medical staff and that the expenditure of the hospital will thereby tend to increase' (KFCMS, 1905). The committee also argued that there was no real need for the first three years of medical education to be conducted in the environs of the hospital. Rather, they said that a common series of lectures that would be made available to students in their early years and that this was in line with the statutes of the University of London. This potentially meant the diversion of students from the first three years to a central

teaching institute. The committee accepted that there were benefits to the hospital from having an attached medical school, but argued that these were not greater than the benefits received by the medical school from having an attached hospital. Overall, they argued that there was support of certain schools through the hospitals and proposed that:

> "for the future ... the distinction between the hospital and the school should in every case be drawn, not only definitely and exactly, but with such clearness that it may be understood by the general public, and so that no question may arise as to the destination and application of moneys contributed, whether by the King's fund, or from any other source" (KFCMS, 1905)

When the annual meeting of the KF took place in March 1905, Prince George commended the report and suggested that the council of the fund should begin to act on its recommendations in 1906. The hospitals were, therefore, given the intervening nine months in which to 'consider their position' (*The Lancet*, 1st April, 1905, p. 883). He did not insist that all hospital funding should be kept separate from medical schools, but said that 'all that we will ask is that the whole of the grants from the KF may go to the relief of the sick poor. If a general account is kept for that exclusive purpose, out of which only hospital payments are made, and into which all ordinary receipts for the general funds of the hospitals are paid, then we are satisfied to make our grants to that account' (p. 883).

The proposals caused a storm of protest from many in the medical profession. Henry Morris, senior surgeon at the Middlesex, published a lengthy paper in *The Lancet* in which he argued that to portray equity of benefit between the school

and the hospital was wholly inappropriate in the light of the good works done by the great numbers of practitioners that had been trained in the schools (Morris, 1905). As far as the central teaching institute was concerned, he regarded it as too expensive to implement. He also bemoaned the authority exerted by the KF given the relatively small percentage of hospital income that it provided, but feared that the Sunday Fund would inevitably follow suit in withdrawing its support, which would make the loss altogether more serious for any that did not comply. *The Lancet* accepted much of what Morris said, although it argued for the academisation of the first three years of medical education. However, it did not support Morris's call for an alternative to the KF's recommendations. 'It is clear' it said 'that no hospital should run counter to the wishes of the KF, for this Fund and the Metropolitan Hospital Sunday Fund represent order and organisation on medical charity and as such are regarded as public safeguards' (*The Lancet*, 20th May, 1905, p. 1362). The Sunday Fund did adopt a motion to accept the terms of the KF's committee and although the position of the KF itself was somewhat fudged as a result of an anti-vivisectionist attempt to get much more draconian measures put in place, the hospitals gave in and the medical schools were forced to seek other forms of support. All the hospitals were required annually to submit a statement that they had not supported their medical schools out of general funds and in general they did not complain, although St. George's found its grant withdrawn after the KF made the judgement that it was paying too much for the facilities for its medical

laboratories[20]. Also, by the end of 1905, two of the hospitals had already taken steps to centralise the teaching of their early year students, establishing conclusively that even the mighty medical profession had to accede to their demands (*The Lancet*, 23rd December, 1905, p. 1857).

6.6.3 Systemic Problems Tackled by the Funds

The funds, led by the KF, continued to conduct analyses on various 'hospital problems' and put pressure on institutions to comply with their views on how to deal with them. The hospitals were encouraged not to spend incoming legacies, but rather to capitalise them, thus securing steadier income streams for the future. This was reinforced by the KF's insistence that all new building should first be approved by them. New hospitals were discouraged and the KF insisted that any new foundations which did go ahead must be able to support themselves for at least three years before they could apply for a grant. Existing small hospitals and specialist hospitals with the same specialism were encouraged to merge and while this was initially a slow and tortuous process, there were significant successes, for example when three orthopaedic hospitals agreed to merge in 1905 (*The Lancet*, 16th December, 1905, p. 1794). In the same year the annual meeting of the King's Fund was able to report its first success in persuading one of the hospitals crowded into central London to relocate into the south of the city. The fund made an extraordinary grant 'for the removal of King's College Hospital ... in order to further

[20] St. George's management made at this time the most determined campaign of resistance to the fund but within three years they were forced to comply and return to the fund for money.

this most desirable undertaking' (16th December, 1905, p. 1794). The problem of 'hospital abuse', where financially solvent members of the public were seeking free medical advice at the hospitals rather than attending a charging general practitioner, remained somewhat intractable, but significant steps were taken, when the MHSF insisted on hospitals with out-patient departments employing an almoner to ascertain whether attendees were genuine objects of charity. There was no issue relating to the management and organisation of the hospitals on which the funds, generally led by the KF, did not take a view.

The hierarchy of the funds and their status in the world of hospital organisation was finally established, when, following the crisis in the voluntary hospitals in the wake of World War 1, the Ministry of Health commissioned the Cave Committee to find a solution. The outcome of this was the proposal of a substantial government grant and the formation of a Hospitals Commission to oversee it. The King's Fund was chosen to be the Voluntary Hospitals Committee for London under the new Hospitals Commission, recognising its status as the body which already managed and organised the London institutions (Prochaska, 1991, pp. 91-95) a situation which carried on in until the formation of the NHS in 1948.

6.7 Summary and Conclusion

This chapter has shown that it was not simply enough for the reformers, such as Burdett and *The Lancet*, to attain the adoption of the Uniform System of Accounts

by the Metropolitan Hospital Sunday Fund. It was necessary for the fund to apply pressure, through the insistence that it was a precondition to application, to get the hospitals to provide the information in the required form. This is the general theme of the chapter. With each subsequent stage, the management of the funds had to apply levers of power in order to achieve compliance with their wishes. Once the MHSF had the information there was a realisation that there were limits to the ways in which it would be used, probably as a result of the commitments given by its founders to individuals of high status. In any case it was soon clear that the action taken by the Fund would be extremely limited.

Burdett's constant publication of data and analyses was significant, but again limited, both by the nature of the publication and by the limits of his authority in such matters. It is possible that his work influenced potential subscribers but that is impossible to determine effectively. Additionally, his thoughts on hospital management had no direct linkages to the managers themselves. He could make judgements, but they could simply ignore them, and they would not be certain of the effect that Burdett's work was having on their fundraising, although they may have had some anecdotal input from the public.

So the problem was essentially one of authority. The information gathered using the uniform accounting system had established a confidence in the quality of the pronouncements of the analysts. What was missing was the authority to make the hospital managers act on the information. The Sunday Fund had, as has been

said, some potential to achieve this, but that potential was limited both by the status of the fund's management and by their willingness to press their requests home. The inability to gain consensus over a Central Board of Control ultimately could have brought the situation to a stalemate. Burdett, however, seems to have anticipated the problem and sought to remedy it once and for all by placing the person of the highest possible status at the head of the action. When the Prince of Wales Fund was formed and the Prince was made Vice-Patron of the MHSF, the level of intervention changed enormously. From its inception the PWF made clear that its motive was not just fundraising, but significant intervention in the management of hospitals in order to limit both the damage done by maladministration and the waste created by lack of coordination. With the presence of the Prince at the head of the funds and with the constellation of the aristocratic and powerful on the council of the PWF, the credentials of the funds became unchallengeable. Nor, could the PWF have been identified as a group that had no knowledge of the sector. With Burdett's help the Prince had long been established as a person with significant interest in the voluntary hospitals and was seen to have considerable knowledge in their affairs. This was a powerful combination. With the involvement of the Prince neither the integrity, status, or knowledge of the head of the funds could be challenged, and because many that involved themselves in the management of the hospitals did so, to a significant extent, to increase their own social status, it is highly unlikely that they had the desire to challenge the funds at this juncture.

With this established the last major link to the creation of an effective mechanism of control over the hospitals was created. The quality of the information was unchallenged, as it focused on accounting information, which was outside the domain of medical knowledge and which, in the form of the uniform system, was regarded by the more business minded as appropriate to create the kind of comparative statements that gave the funds something upon which to base their judgements. The involvement of Burdett gave the accounts further credibility as he was undoubtedly seen as the foremost authority in this area. The creation of the PWF/KF with its unchallengeable leadership and its use of the uniform accounts as the basis of its information gathering created the linkage between the information, the judgements and the power to exercise judgement. The power to force hospitals to comply was significantly leveraged by the wide publicity given to its awards, which allowed the ordinary subscriber to target their own contributions to those institutions that had the funds' approval and further still by the synchronisation of decision making between the funds which meant that a hospital that lost it's grant from one fund risked losing it from the other, and perhaps from the Saturday Fund as well. Thus the overall weight of funding that a hospital risked by defying the funds was likely to have very serious consequences for its long term survival.

Thus armed, the hospital funds began to conduct their analyses of the accounts with fresh vigour and with increasing authority, to insist that the hospitals modify their management practices to comply with the wishes of the funds. As well as tackling the specific inefficiencies of individual hospitals, the funds were able to

overcome what they saw as inappropriate practice amongst the hospitals as a group and to tackle what had been long running and previously intractable problems. These included issues such as: the policy of adopting legacies as capital rather than income; the coordination of provision within the city through restriction of new development without permission, the relocation of existing provision to areas of greater need and the merging of small, relatively inefficient institutions onto bigger units; and finally the placement of almoners in all the out-patient departments to tackle the long standing problem of hospital abuse.

Of course it cannot be in any way argued that the funds were able to solve the hospital problems of the Victorian era; that is not the contention of this chapter or this thesis. What is argued is that with the use of uniform accounts a system was created that offered the potential to go beyond the creation of accountability. The visibilities created by the accounts offered the potential to go beyond accountability and into management. The construction of the funds allowed this potential to be realised and created an authority that turned the hospitals from being a disparate group of autonomous institutions into a hospital system; a system that was to become increasingly established and, with the later creation of the Nuffield Provincial Hospitals Trust, become a system that was not restricted to London, but which was national in character. Ultimately, although the demonstration of this is beyond the scope of this thesis, it was the structures created by these systems that were to form the foundation of the administrative framework of the National Health Service when it was created in 1948.

What we can see with this example, is, on a very large scale, the kind of formation of 'state' structures argued by Foucault and elaborated by others. It is this coalescing of structures of language, however numerical they may be, and their adoption by the establishment that allows for new ways of thinking and new modes of action. It is a bottom-up understanding of the formation of the State, rather than the typical top-down understanding that we have seen more traditionally. With this particular problem it is clear that the keystone was the accounting system. Without that it seems highly unlikely that the reformers could ever have overcome the initial hurdles created by hospital managers who claimed that the information the reformers were using was flawed. The uniform accounts created the stable analytical language that allowed the reformers to speak authoritatively about hospital issues and in due course to convince those with the power to create change to get involved and enable it.

7. CONCLUSION

This thesis has examined a number of forms, or attempts to create forms, of hospital reporting. In so doing it has sought, from the perspective of foucauldian governmentality, to try to understand how these practices emerged, became embedded and were subsequently constructed as mechanisms whereby the exercise of power could take place. In this the work has two intents: firstly as a critique of simplistic understandings of reporting practices as a mechanism of accountability; and secondly to explore the extent to which reporting practices and the reported information, at least in the 19th century hospital system, offered the potential for authoritative groups to use that information to exercise power over other groups or institutions. To this end the work has explored the reporting practices: firstly, of a single institution; one which was held in the highest regard, both for its clinical administrative expertise; and secondly of a group of institutions in a specific geographical location.

The study was also highly contextualised on the grounds that the circumstances were so specific that the reporting practices could only fully be understood in this way. It was established that the voluntary hospital movement came out of a pat-

tern of desires: to relieve suffering and disease to which all were exposed and vulnerable; to improve the economic health of the nation by making the unproductive and costly sick poor back into healthy, productive, contributing individuals; to enhance the benevolent individual's prospects in the afterlife; to increase the benevolent individual's social standing by constructing themselves in the image of philanthropers. From this came the establishment of large general hospitals for the relief of the sick poor all over the United Kingdom, and in other countries as well. The scale of these institutions and the substantial resources that they consumed, increasingly became the object of attention for those that questioned whether the resources were being used effectively. As a result, the hospitals began to issue annual reports offering accounts of their activities over the preceding year.

In the first case the annual reports of the Royal Infirmary of Edinburgh were explored. The content of these large documents included details of the activities of the hospital's activities during the year and lists of the names of the philanthropic public that had made the donations and contributions that were required for the financing of the hospitals activities. Ostensibly, they were mechanisms where the management of the hospital could be held accountable and where philanthropists could gain recognition for their benevolence. However, as was shown by the work of Borsay (1991a, 1991b, 1999) and others, the ability of the benevolent to hold the management of the hospitals to account was severely restricted by the inability to see whether or not the costs and expenses were reasonable or not. The unrestricted flexibility of presentation allowed for expenditure to be allocated according

to the whim of the manager and discrepancies between institutions were dismissed as merely accounting differences, thus the usefulness of the information for accountability and/or control was severely limited. The reports had other uses though. Far from being constructed for the sole use of the financiers of the organisation, it has been shown that the main users of the annual reports were in fact the managers. While this is counter-intuitive to modern understandings of such documents, it has been shown that the hospital management used the reports for two main purposes.

The first purpose that the managers used the reports for was the promotion of the institution itself. Much of the material in the report could be viewed as propaganda; displaying the great good works of the hospital and, by showing the large numbers of patients treated, how effective it was for its chosen purpose. That these figures were typically manipulated has been established (for example: McMenemey 1964, Borsay 1991a, 1991b, Berry 1994, 1997). Two primary examples of such manipulation were the refusal to admit anyone who appeared that they may die in the hospital, (and the removal from the hospital of those that were not responding to treatment), and the creation of out-patient departments where large numbers of cases could be treated at little cost. These practices greatly inflated both the amount of work that appeared to have been done and the rate of success in doing it and, in doing so, persuaded the philanthropic public that the institution was worthy of support and continued financing.

The second purpose for the annual reports is even more counter-intuitive than

the first and developed over time, rather than having been an initial feature of the reports. As has long been established in the accounting literature, accounting reports can create visibilities of the outcomes of human action and by this means people can be governed within an organisation (for example: Miller and O'Leary 1987, Miller and Rose 1990, Roberts and Scapens 1990). What the managers of the Royal Infirmary of Edinburgh realised was that with the information that they routinely published with the names of subscribers and donors could be structured to create fields of visibility of the actions of those individuals and others with respect to their financing of the hospital. This information could be sent to individuals so that they could see how their benevolence compared to that of others in similar circumstances. The process was reinforced by the use of collectors who would visit each individual and consult the report to see what that person had, or had not, given the previous year and to see how it compared, for example, to others in the same street, or area. In this the collector is working like a surrogate manager, or authority, examining the performance of the individual philanthroper. To refocus the words of Brass (2000, pp. 308-9) into a different context '[t]hey exercise that power through the examination by turning the individual from a citizen, who may belong to a broader group of like-minded citizens with potential influence in society, into an "effect and object of power" and of knowledge'

The particularly unusual features of this practice in terms of annual reporting are twofold: firstly, the visibility created extends, not into the organisation itself, but outwards from the organisation and into the community in which it is located;

and secondly, the target of the information, i.e. the individuals that are made accountable (governed) by it, are the individuals that finance the organisation. This demonstrates a reversal of a widely observable assumption that is applied to annual reporting practice; that it is about making managers accountable to the financiers and further, that accounting reports in general are for the benefit and use of those higher up the organisational hierarchy to manage or govern those further down. What this thesis demonstrates is that accounting information, by structuring it and applying it, potentially can be used to create organisation and government where none existed before, not only within the established organisational boundary, but also to create new organisational structures in any area for which the data can be collected and applied. The domain of the governed can be extended into those areas where the analyst has data about the governed in the way that the government uses campaigns or technologies to act on the population (1990, p. 100). Thus in this instance the techniques of surveillance and discipline exercised by the managers of the RIE enable them to exercise action at a distance and to become a form of government over the quality of philanthropy. What emerges is an example of government at a micro level, outwith the domain of the state where a subset of the population are directed to act in a particular fashion as a result of the visibilities created.

Yet care must be taken to avoid being too simplistic. The notion of governmentality does not suggest that we are at the mercy of the data gatherers, who could collate information on our activities and compare it to that of others, thereby

persuading/embarassing/compelling us to act in the way that they chose. If this were the case then Curtis (1995) may have genuine grounds for his accusation that governmentality extends the concept of government to the whole of human interaction. Some might argue that this kind of control through calculative technologies does happen far too much in modern society, but it seems logical that we can only be so persuaded if we are in some way intellectually or emotionally engaged in that activity; i.e. if we believe that we should conform to the norms of behavior as demonstrated by others. This worked for the managers of the hospital, because those who gave to the finances often had a selfish motive for doing so in terms of their desire to be seen by their peers as benevolent philanthropists. When the annual reports structured the donations and contributions, they also restructured the originators of those monies from having simple polar values, (either a contributor, or not a contributor), to having a qualitative aspect as either a contributor, or not. How benevolent is an individual really, when his neighbours are able to contribute so much more? How uncharitable is a person when he does not, from such an apparently wealthy area, contribute at all? Thus, through the desire of individuals to have their contribution recognised, were those individuals engaged, captured and made governable by the collection and structuring of information about their activities. It could be argued then that, regardless of the extent of control that an individual, or organisation, has over an information set, without the engagement into and acceptance of that information by the individuals who are the subject of it, it would have limited meaning for, and limited power over, them. What is seen

in the RIE case is an instance of the operation of power that attempted neither to extend itself to the whole of human interaction, nor to identify government with a single monolithic conception of the legislative state. The limit to the power of the hospital managers was the the extent to which the general population engaged with the technology; i.e. whether or not they sought to have themselves identified as philanthropic.

The central role of this engagement of the population can be seen in the second case examined by the thesis. In this case, the first attempt to create some organisational structure and control over the hospitals is reviewed. This attempt arose out of the growing awareness in the second half of the 19th century that voluntary hospitals were growing in number, size, complexity, concentration (especially in London), demands for resources and in the number of social issues that were emerging in relation to them, and yet there was no body, or bodies, that were in a position to effectively examine the activities of these institutions and decide if their activities were economic, or efficient, ways of dealing with the problem of the sick poor. In response to this a group of reformers emerged that sought to find mechanisms whereby they could exercise power over the hospitals and their management. They sought to do this by constructing systems of uniform reporting that allowed the analyses of hospital activity on a comparable basis which would highlight abnormal practice and allow the reformers to apply leverage by influencing the funding arrangements of the hospitals.

It was the perceived problems of the hospitals that provided the spur for action. The main difficulty was that there was no effective way to assess what the hospitals were achieving. As has been shown, the accounts and reports were so wildly differing in preparation and presentation that any criticism derived from a comparative analysis of the reports could simply be ascribed by the hospital managers as differences in accounting. From this, Florence Nightingale and her friend William Farr sought to construct and implement a system of Uniform Hospital Statistics, which covered all the informational provision of hospitals from diseases treated, to outcomes, to costing of the treatment of patients. What the pair desired was that each hospital should provide the information in a standard form, which would then allow them to conduct analyses showing examples of practice that deviated from the norm.

This plan, despite receiving much media support from journals such as *The Lancet* was never achieved for a number of reasons. Amongst these reasons was the fact that they managed to alienate those involved in the hospitals, including the very powerful medical profession, who were important to the success of their scheme. The problem was that the doctors and managers were suspicious of the motives of Nightingale and Farr. Nightingale in particular, had come back from the Crimean War with the belief that hospitals were places of death and were not the best way to treat the sick. There was, it seems, a sense amongst the managers and hospital doctors that the data gathered under the uniform statistics scheme would be used at least to provide heavy criticism of the hospitals and their activities, but

perhaps may have another agenda; to go so far as to close them down. Farr did nothing to alleviate concerns with his focus on hospital death rates as the primary measure of performance. This would have led to virulent opposition, as both doctors and managers got great benefit from their involvement in the hospitals, either as demonstration of their medical excellence or as a means of promoting their social status through contact with the wealthy and the aristocratic. Nightingale and Farr continued to argue for adoption, but the scheme was challenged by doctors on the basis of the nosology of disease produced by Farr and on the accuracy of the death rates that they projected. Farr, they argued, both had no medical qualifications and was over-zealous in his calculation. Swinging the debate towards scientific understandings of the causes of disease, rather than the engineering orientated attempts to prevent it that were promoted by sanitarians like Nightingale and Farr, the doctors managed to maintain authority over the production of the statistics of death and undermine the authority of the Uniform statistics scheme. Thus the scheme failed in the early stages. The Uniform Hospital Statistics had the potential to act as a mechanism of power that could have influenced medical and hospital management, but the inability of its promoters to achieve its implementation left it stillborn.

Alongside this failure, there was another factor that was central to the demise of their scheme. Nightingale and Farr had never really managed to establish a powerful lever to engage the public in the debate and promotion of the system of statistics. For the lay public the hospital death rates published by Nightingale

and Farr may have seemed alarming, but it had little real effect on them. After all it was not the subscribers who were the users of the hospitals and there was sufficient conflicting information to allow ambiguity over who actually had the correct numbers. The ability of the doctors to cast doubt on the calculations produced by Nightingale and Farr really defused their arguments and left them with nothing else to give weight to their demands for uniformity. Thus the failure to get any of the parties concerned to engage with their calculus meant that the scheme was lost without hope of recovery and the need to overcome a number of obstacles to get any effective scheme in place was highlighted.

What is remarkable about what happened in the ensuing three decades is that we can observe the gradual formation of structures and systems which overcome the difficulties experienced by Nightingale and Farr. Over the years, reformers seem to have realised that there was nothing but failure facing any attempt to control hospital activity on the basis of information grounded in medical language. Either realising that control over medical practice was too difficult, or regarding such as a secondary aim, the campaign was launched to get comparative data from the hospitals on the basis of administrative language in the form of uniform hospital accounts, after the issue was raised, first by the Social Science Association and subsequently supported by the Statistical Society, before being taken up by *The Lancet*.

With this tactic the medical opposition was defused. All the emphasis of the

campaign was placed upon economy and efficiency and the clinicians could say little about this as there was no obvious way in which the search for efficiency in administration could impact upon medical practice or decision making. In addition, there was little that the hospital managers could protest about. They certainly could not be seen to oppose anything that was proposed as a means of establishing efficiency without the public wondering what they had to hide. The credibility of the accounting system itself was established by the provenance and energy of Burdett, who established it in Birmingham in 1869, and was always at pains not just to defend the system, but to modify it as necessary to accommodate responses to criticism. With this, the reformers were able to argue for adoption without receiving any major opposition to their claims. Nevertheless, there was no take up of the system by the hospitals as the managers again had no particular desire to engage with the reformers and the reformers still had no lever strong enough to persuade them to do so.

Eventually, the breakthrough was made by linking the demand for a set of accounts from each hospital, that was prepared upon a uniform plan, to the provision of a grant through the Metropolitan Hospital Sunday Fund. With this, reformers such as Burdett and Wakley launched a prolonged media campaign to achieve their goal. When they succeeded in persuading the Sunday Fund to insist on the uniform accounts they achieved their aims. Now opposition from hospital managers was more difficult as the extra work involved in the preparation of the accounts was offset with the promise of a grant. Nor were they in any way compelled to seek

the grant and release the accounting information should they choose not to do so. Thus opposition to the scheme had little to focus on and soon the Sunday Fund and Burdett were in possession of accounts from all the hospitals prepared under the uniform plan.

Despite this the reformers had still not placed themselves in a position to exercise power over the hospitals. Certainly the accounts were there and by this stage suffered no significant challenges. The hospital managers were to some extent complying by providing the required information and they could hardly challenge it since they had provided it. Also, the accounts were supplying Burdett with the information that he required to conduct his analyses of hospital problems; enabling him to be critical of specific issues with authority. However, the required authority to make demands upon the hospitals' management boards was still lacking. The necessary final connection between problem identification and the ability to generate action to resolve the problem was still lacking, because the funding supplied by the Sunday Fund and the signal it gave to the public was insufficiently contingent on the compliance of the hospital managers with the wishes of the Fund. The managers of the fund seemed unwilling to upset the powerful members of the management committees of the hospitals. At this point the technology of power required by the reformers, in the form of the uniform accounts is in place, but the will to use it is not. Burdett is able to conduct the analyses that he wishes, but is unable to use them to exercise power over hospital management as the Sunday Fund management refused to assert that the hospitals must comply with their

requests.

To create the final trigger needed to send appropriate signals to the public and to persuade the fund that they had the authority and power to act against the hospitals, Burdett involved the Prince of Wales as vice-patron of the Sunday Fund and assisted in the creation of the Prince of Wales Fund. With this the question of authority was resolved. The Prince persuaded a large number of very powerful people to become involved in the management of the PWF to the point where it was clear that there would be no issue over making demands of the hospitals' management. Such was the status of the management of the PWF that the public looked to it for guidance on which hospitals should receive contributions and status seekers in the managing committees of the hospitals would rarely speak out against the Fund's pronouncements. The PWF quickly established itself, with the uniform accounts as its core information system and began to organise and coordinate the London hospitals. Resistance was rare and ultimately always crumbled, due to the authority of the country's best known philanthropist and the ability of that authority to engage the rest of benevolent society into the information provided by the accounts.

In the end it was clear that what had been created by the uniform accounting system was an organisation where none had been before. Like the Reports of the RIE the information was able to create structures and visibility where there had been none. With these visibilities groups were able to make claims for action

upon other individuals and groups. These claims for action were only recognised, however, when there was either full engagement of the individual in the activity under scrutiny as in the case of the subscribers to the RIE, or where there was sufficient leverage applied through the engagement of a large body of individuals as in the case of the Sunday Fund and the PWF/KF. What happened in the first instance was that the annual reporting allowed the managers of the hospital to gain power over the contributors in order to persuade them to give more, and in the second instance the annual reporting through the uniform accounts allowed the contributors to gain power over the hospitals. What has been shown is the way in which the reports allowed the construction of technologies of government that could be focused in any direction as long as those to be governed could be brought into the range of the technology being deployed.

The key to this was the engagement of the individual with the technology. In the case of the RIE the individual subscribers had voluntarily engaged, because in general they sought to gain status and potential social advancement through their involvement. It was necessary for the hospital reformers to re-engage these same people with a different system in order for them to achieve their reforming objectives. They did this by creating an aura of status and power around the PWF/KF that was attractive to the subscribers partly for the same reason that they wished to have their names published in the lists of the hospitals' annual reports; i.e. they wished to be seen as associating with the powerful. But also the subscribers wished to be seen as rational individuals and to target their philanthropy where it would

be most efficiently used. Thus with this exercise of influence over the subscribers and the additional ability to grant or withhold monies raised by the Fund the managers of the funds, acting largely in tandem, were able to exercise control over the managing committees of the hospitals and achieve their reforming ends.

There are of course a number of limitations to what has been discussed here. The primary focus of the work has been in the public debates that surrounded the practice of annual reporting by the hospitals, mainly but not exclusively in the medical press. The study could be enhanced by the examination of the archives of the London hospitals concerned, but this is a very large undertaking and will require the work of many years. Additionally, the scope of the work could be taken closer into the domain of the professional accountant, although a search of *The Accountant* suggested that there was limited engagement in the professional accounting press. Constraints of space and scope have also made it impossible to seek data that might reveal how the exercise of power through these annual reports was received by the individual. Outside of published comments made by individuals, this would require the identification of personal journals of individuals, which might include reminiscences that relate to the hospitals. All of these are worthy objects of study, but fell beyond the scope of this thesis and will instead be addressed by further work in this area.

APPENDICES

Appendix A

Resolutions of the Committee on Hospital Statistics

1. That this meeting considers it of the utmost importance that the metropolitan hospitals should adopt one uniform system of registration of patients.

2. That this meeting recommends, that at every metropolitan hospital, there be kept one or more books. which shall comprise the following particulars relating to the patients :—the Age, Sex, Social Relation (Mar., Single, Wid.), Occupation, Name of Disease, or Injury, Date of Admission and Discharge, Result, Days in Hospital, and a column for remarks.

3. That in the case of those hospitals which have not yet adopted a system of registration embracing the above particulars, It is recommended that they employ a register book containing all the annexed particulars in printed columns:—

   Number of Patient. | Date of Admission. | Name. | Residence (Street and Parish). | Medical Officer. | Ward. | Age. | Male. | Female. | Soc. Relat. (M. S. W.) | Occupation. | Name of Disease or Injury. | Date of Discharge. | Result. | Days in Hospital. | Remarks.

   It is further suggested that the first set of headings commencing with "Number," and terminating with "Ward," be printed on the left hand page, and that the remainder be placed on the right hand page of the Register ; and it will also be found convenient if each page of' the register book should be ruled to contain either 25, 50, or 100 horizontal lines, each line to give the particulars of an individual case.

4. That this meeting recommends, that as far as practicable in the column of the register book headed Disease or Injury, the nomenclature employed by the Registrar-General be adopted, with the additions contained in the forms submitted by Miss Nightingale to the International Statistical Congress.

5. That the Council of the *Statistical Society* having kindly undertaken to publish in their *Journal* some of the leading statistics of the metropolitan hospitals, if provided annually with the necessary information, the authorities of the several metropolitan hospitals be requested, at the close of each year, to draw up and communicate to that Society a summary of the statistics of the hospital for the year; such summary to comprise the data tabulated in the manner represented on the accompanying form.

6. That it be suggested to the authorities of the several metropolitan hospitals, that it will be of great public advantage if they will also publish annually a full report of the statistics of disease treated within the hospital, following, as far as practicable, the arrangement and nomenclature employed by the Registrar-General and by Miss Nightingale in the paper referred to in the third resolution.

7. That in the opinion of this meeting, it is essential there should be in every hospital an officer charged specially with the duty of attending to the registration of patients.

Appendix B: Additional Statement Templates from the Uniform System of Hospital Statistics

THE following heads for a Hospital Admission and Discharge Book will afford a ready means of collecting the data required for filling up the annual forms proposed in this section. They also include those particulars in regard to cases of disease contained in the additional propositions adopted by the Congress.

HOSPITAL ADMISSION AND DISCHARGE BOOK.

No. of Case.	Date of Admission.	Name.	Age.	Sex, M. or F.	Residence, and Place where taken ill, or Injured.	Trade or Occupation.	Disease or Accident.	Date.					Duration of Case in Hospital in Days and Quarters.	Remarks. — (Previous Diseases of Patients and of Parents.)
								Of Attack.	Of Recovery.	Of Death.	Of Discharge, (Relieved) or (unrelieved), or otherwise.	Of Transfer to other Division of Hospital.		

NOTE.—If a patient admitted for one disease (such as ulcer) is attacked by another disease (such as erysipelas), unconnected with the former, the patient *should not be "discharged."* The new disease should simply be entered as *another case*, and the date of recovery from the first disease (ulcer) should not be filled up until the ulcer is healed. At the same time as the entry of the new disease (erysipelas) is made, a note should be written in the discharge column of the admission for ulcer, simply referring to the new number under which the case is entered, thus (See No.). The date of recovery, death, &c., from the second disease, erysipelas, must be entered in the proper column opposite that disease.

Item 1: Hospital Admission and Discharge Book

HOSPITAL GENERAL STATISTICAL FORM.

This Sheet will serve for the Classification of Cases in Hospitals under the following headings:—"Remaining, 1st January"—"Admitted"—"Cured (or Relieved)"—"Dead"—"Discharged incurable, for Irregularities, or at their own Request"—"Remaining, 31st December"—"Duration of Cases in Days."

Write the Name of Hospital, the Sex, the required Heading, and Date, with the Pen.

Ages	Months. 0	3	6	1	2	3	4	5	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	95 and upwards.	Total.
CLASS I.—Order I. (Zymotic Diseases.)																											
1. Small Pox																											
Measles																											
Whooping Cough																											
Croup																											
Scarlatina																											
Quinsy																											
Diphtheria																											
Coryza, Catarrh, Influenza																											
Ophthalmia (purulent)																											
Erysipelas																											
Metria (puerperal Fever)																											
Pyæmia																											
Hospital gangrene																											
Carbuncle, Boil																											
Dysentery																											
Diarrhœa																											
Cholera																											
Typhoid Fever (typhia)																											
Typhus																											
Relapsing Fever (typhinia)																											
Ague																											
Remittent Fever																											
Rheumatism																											
OTHERS																											
Order II.																											
Gonorrhœa																											
Primary Syphilis																											
Secondary Syphilis																											
Tertiary Syphilis																											
OTHERS																											
Order III.																											
Scurvy																											
Purpura																											
Alcohol (a. Delirium tremens; b. Intemperance)																											
OTHERS																											
Order IV.																											
Thrush																											
Porrigo																											
Scabies																											
Worms																											
OTHERS																											
CLASS II.—Order I. (Constitutional Diseases.)																											
Gout																											
Dropsy																											
Cancer																											
Canker (noma)																											
Mortification																											
OTHERS																											
Order II.																											
Scrofula																											
Tuberculosis Mesenterica																											
Phthisis																											
Hæmoptysis																											
Pneumothorax																											
Hydrocephalus (with tubercular deposit)																											
OTHERS																											
CLASS III.—Order I. (Local Diseases.)																											
A. Brain, spinal marrow, and nerves.																											
Meningitis																											
Cephalitis (including acute hydrocephalus)																											
Paralysis																											
Chorea																											
Mania																											
Epilepsy																											
Hysteria																											
Tetanus (idiopathic)																											
[illegible]																											
Phlegmon																											
Whitlow																											
Abscess (external)																											
Ulcer (external)																											
OTHER SKIN diseases																											
CLASS IV.—Order I. (Developmental Diseases.)																											
Spina bifida																											
OTHER malformations																											
Teething																											
OTHERS																											
Order II.																											
Chlorosis																											
Childbirth (Miscarriage; Abortion, &c.)																											
Paramenia (including Amenorrhœa, Leucorrhœa, Turn of Life, Climacteria)																											
CLASS V.—Violent Deaths or Diseases. Order I.—(Accident.)																											
Burn																											
Scald																											
Fracture																											
Contusion																											
Concussion																											
Gunshot wound																											
Cut, stab																											
Poisoning																											
OTHERS																											
Order III.—(Homicide.)																											
Order IV.—(Suicide.)																											
Gunshot wound																											
Cut, stab																											
Poisoning																											
OTHERS																											
Sudden deaths (cause not ascertained)																											
Causes not specified or ill-defined																											
Total																											

Most of the diseases in the following marginal list are of less frequent occurrence in hospitals; and all, with some exceptions, are *classed as* "Others" in their respective orders in the left-hand column. They will be distinguished in abstracting the diseases by writing the *ages* of the persons attacked, cured, or dead, &c., against the particular disease in the margin below. Thus, a person aged 16 would, if admitted for "mumps," be indicated in the body of this sheet by *a tick* against "Others" of Class I. Order I.; and his age (16) would be written against "mumps" in the margin. And so of other diseases. The diseases not found printed in the margin must be written in their proper compartments. A summary of the facts in the margin should be given in an appendix to the general Table.

CLASS I.

Order I.

varioloid
varicella
miliaria
mumps
erythema
dysentery with abscess of liver (placed to *dysentery*)
yellow fever

Order II.

leprosy (Greek elephantiasis)
yaws
glanders
hydrophobia
malignant pustule
necusia*

* *Infection by puncture in dissection or by handling the parts of dead animals.*

Order III.

rickets
bronchocele
cretinism
ergotism

Order IV.

phthiriasis

Hydatids, tape worm, and other entozoa should be distinguished here. In the capital table they will be added to the head "Worms."

CLASS II.

Order I.

anæmia
lupus
dry gangrene
bed sore
melanosis

The several forms of cancer comprised in the capital table under the head "Cancer" should be distinguished as under; the ages, and parts affected, should

lichen
prurigo
psoriasis
pityriasis
ichthyosis

In abscess and ulcer the parts affected should be distinguished here.

CLASS IV.

malformations
anus imperforatus
cyanosis
decay of old age
atrophy and debility

CLASS V.

Order I.

explosion of powder, gas, &c. (placed to *burn*)
chilblains
frost-bite
lightning, (where struck and how?)
sun-stroke (state circumstances)

The circumstances attending deaths by violence should be shown in detail; as, for example, how many persons, at their several ages, were burnt by their clothes taking fire, how many died by falling from scaffolds or heights, how many were poisoned by arsenic, opium, quack medicine, over-dose, &c. Gunshot wounds should be distinguished as regards the species of weapon,—rifle, pistol, cannon, &c.; other wounds, as whether inflicted by knife, dagger, &c. When cases of privation, drowning, hanging, suffocation, fall within observation, they should be placed to "Others" in the general Table, and the particulars should be stated here. All violent deaths should fall under one or other of the three orders: Accident—Homicide—Suicide.

[*To face p.* 160]

Item 2: General Statistical Form

NAME of HOSPITAL .....

PERIOD INCLUDED in this TABLE—from ..... to .....

(The Period should be the same as in Table II.)

TABLE I.—SURGICAL OPERATIONS PERFORMED.

OPERATIONS.	Under 5 Years.		5—		10—		15—		60—		65—		70—		75 and above.		TOTAL.		RESULTS. Recovered.		RESULTS. Died.		DISEASES OR INJURIES REQUIRING OPERATION.	COMPLICATIONS OCCURRING AFTER OPERATION, [After each complication, give the age of the patient.]	Average Duration in Days from Operation to Result.†	Remarks on Constitution of Patient, &c.
	Males.	Females.	Males.	Females.	Males.	Females.	Males.	Females.	Males.	Females.	Males.	Females.	Males.	Females.	Males.	Females.	Males.	Females.	Males.	Females.	Males.	Females.				
AMPUTATIONS.* (FOR INJURY.)																										
Primary :—																										
Hip Joint																										
Thigh																										
Leg																										
Foot																										
Toes																										
Shoulder Joint																										
Arm																										
Fore-arm																										
&c., &c., &c.																										

* Under amputations through any part of the limb should be included amputations through the joint next above that part, unless where the amputation at the joint is extremely

† As a general rule, the result should be considered as attained at the date of the healing of the operation wound.

[To face p. 172].

Item 3: Statement of Surgical Operations Performed

NAME of HOSPITAL: .....

PERIOD INCLUDED in this TABLE—from ..... to .....

(The Period should be the same as in Table I.)

TABLE II.—MORTALITY IN SURGICAL OPERATIONS.

OPERATIONS.	AGE AND SEX.																		Total Deaths.		DISEASES OR INJURIES REQUIRING OPERATION.	FATAL COMPLICATION AND CAUSE OF DEATH. [After each complication give the age of the patient.]	Average Duration in Days from Operation till Death.		Remarks on Constitution of Patient, &c.
	Under 5 years.		5—		10—		15—		20—		30—		40—		50—		60—		65—		70—		75—						
	Males.	Females.	Males.	Females.	Males.	Females.	Males.	Females.	Males.	Females.	Males.	Females.	Males.	Females.	Males.	Females.	Males.	Females.	Males.	Females.	Males.	Females.	Females.	Males.	Females.				
AMPUTATIONS.* (FOR INJURY.)																													
Primary:																													
Hip Joint																													
Thigh																													
Leg																													
Foot.....																													
Toes.....																													
Shoulder Joint																													
Arm																													
Fore-arm																													
Hand																													
Fingers																													
Secondary:—																													
Hip Joint																													
Thigh																													

* Under amputations through any part of the limb should be included amputations through the joint next above under amputations of the leg those through knee joint, unless where the amputation at the joint is expressly named.

[*To face p.* 172.

Item 4: Statement of Mortality from Surgical Operations

LIST OF SOURCES

JOURNAL SOURCES:

The Lancet
The Hospital
The Medical Times and Gazette (MTG)
The British Medical Journal (BMJ)
The Journal of the Royal Statistical Society (JRSS)
Burdett's Hospitals and Charities of the World (BHCW)
Transactions of the National Association for the Promotion of Social Science (TNAPSS)

NEWSPAPERS:

The Times
The Scotsman

ARCHIVAL SOURCES:

The Lothian Health Services Archive at the University of Edinburgh:

LHB1/1/1 - LHB1/1/75:
Minutes of the Committee of Management Of the Royal Infirmary of Edinburgh 1729-1851

LHB1/4/1 - LHB1/4/51:
Annual Reports of the Royal Infirmary of Edinburgh 1801-1851

Archives of the Edinburgh Central Library

YRA 987: 1729-30, 1810, 1812, 1813, 1836-7, 1850-51, 1860-61:
Reports regarding the Affairs of the Royal Infirmary of Edinburgh 1729-1851

BIBLIOGRAPHY

Abel-Smith, B. (1964). *The Hospitals 1800-1948: A Study in Social Administration in England and Wales*. Heinemann, London.

Annisette, M. (2000). Imperialism and the professions: The education and certification of accountants in Trinidad and Tobago. *Accounting, Organizations and Society*, 25:631–59.

Annisette, M. (2003). The colour of accountancy: Examining the salience of race in a professionalisation project. *Accounting, Organizations and Society*, 28:639–74.

Arendt, H. (1968). *Between Past and Future:Each Exercises in Political Thought*. The Viking Press, New York.

Bailey, D. (1992). The attempt to establish the Russian accounting profession. *Accounting, Business and Financial History*, 2(1):1–23.

Bakre, O. M. (2005). First attempt at localising imperial accountancy: The case of the Institute of Chartered Accountants of Jamaica. *Critical Perspectives on Accounting*, 16:995–1018.

Bakre, O. M. (2006). Second attempt at localising imperial accountancy: The case of the Institute of Chartered Accountants of Jamaica. *Critical Perspectives on Accounting*, 17:1–28.

Barry, J. and Jones, C. (1991). Introduction to *medicine and charity before the welfare state*. In Barry, J. and Jones, C., editors, *Medicine and Charity Before the Welfare State*, pages 1–13. Routledge, London.

Bellers, J. (1714). *Essay Towards the Improvement of Physic*. Sowle, London.

Berry, A. (1994). Balancing the books: Funding provincial hospitals in eighteenth century England. *Paper presented to the sixth annual accounting, business & financial history conference Cardiff*, pages 1–20.

Berry, A. (1997). 'balancing the books': Funding provincial hospitals in eighteenth century England. *Accounting, Business and Financial History*, 7(1):1–30.

Booth, C. C. (2000). Medical radicals in the age of enlightenment. *Journal of Medical Biography (Great Britain)*, 8:228–40.

Borsay, A. (1991a). Cash and conscience: Financing the general hospital at Bath *c*1738-1750. *Social History of Medicine*, 4:207–229.

Borsay, A. (1991b). "persons of honour and reputation": The voluntary hospital in an age of corruption. *Medical History*, 35:281–294.

Borsay, A. (1999). A middle-class in the making: The negotiation of power and status at Bath's early Georgian general infirmary, *c.* 1739-65. *Social History*, 24(3):269–286.

Boyns, T. and Edwards, J. R. (1996). The development of accounting in mid-nineteenth century Britain: A non-disciplinary view. *Accounting, Auditing and Accountability Journal*, 9(3):40–60.

Boyns, T. and Edwards, J. R. (1997a). The construction of cost accounting systems in Britain to 1900: The case of the coal, iron and steel industries. *Business History*, 39(3):1–29.

Boyns, T. and Edwards, J. R. (1997b). Cost and management accounting in early victorian Britain: A chandleresque analysis? *Management Accounting Research*, 8:19–46.

Boyns, T. and Edwards, J. R. (2000). Pluralistic approaches to knowing more: A comment on Hoskin and Macve. *Accounting Historians Journal*, 27(1):151–158.

Boyns, T., Edwards, J. R., and Nikitin, M. (1997a). *The Birth of Industrial Accounting in France and Britain*. Garland, New York.

Boyns, T., Edwards, J. R., and Nikitin, M. (1997b). The development of industrial accounting in Britain and France before 1880: A comparative study of accounting literature and practice. *European Accounting Review*, 6(3):393–437.

Brass, P. R. (2000). Foucault steals political science. *Annual Review Political Science*, Vol 3:305 – 330.

Braverman, H. (1974). *Labour and Monopoly Capital: The Degredation of Work in the Twentieth Century*. Monthly Review Press, New York.

Briston, R. J. and Kedslie, M. J. M. (1986). Professional formation: The case of Scottish accountants - some corrections and some further thoughts. *British Journal of Sociology*, 37(1):122–30.

Bristowe, J. S. (1864a). Hospital statistics. *Medical Times and Gazette*, page 186.

Bristowe, J. S. (1864b). Hospital statistics. *Medical Times and Gazette*, page 491.

Brown, L. D. (1996). Influential accounting articles, individuals, PhD granting institutions and faculties: A citational analysis. *Accounting, Organisations and Society*, 21(7/8):723–754.

Brown, R. (1905). *A History of Accounting and Accountants*. T C and E C Jack, Edinburgh.

Buckle, F. (1863). *Vital and Economic Statistics of the Hospitals, Infirmaries, & C., Of England and Wales, for the Year 1863*. John Churchill & Sons, London.

Buckle, F. (1869). Hospital administration. *The Lancet*, 1:278–9.

Bullough, V. and Bullough, B. (1971). The causes of the scottish medical renaissance of the eighteenth century. *Bulletin of the History of Medicine*, 45:13–28.

Burchell, S., Clubb, C., Hopwood, A., Hughes, J., and Nahapiet, J. (1980). The roles of accounting in organizations and society. *Accounting, Organizations and Society*, 5(1):5–27.

Burdett, H. C. (1881). *Hospitals and the State: With an Account of the Nursing at London Hospitals, and Statistical Tables Showing the Actual and Comparative Cost of Management and Maintenance, and of Work Done by the Principal Hospitals, Convalescent Institutions, and Dispensaries Throughout Great Britain and Ireland*. J & A Churchill, London.

Burdett, H. C. (1884). *Hospital Sunday and Hospital Saturday. Their Origin, Progress, and Development, Together with Suggestions for Making Both Funds More Useful to the Hospitals.* The Sceintific Press Ltd., London.

Burdett, H. C. (1889). *Prince, Princess and People: An Account of the Public Life and Work of their Royal Highnesses the Prince and Princess of Wales, 1863-1889*. London.

Burdett, H. C. (1893). *The Uniform System of Accounts, Audit and Tenders for Hospitals and Institutions: With Certain Suggested Checks Upon Expenditure, and Tender and Other Froms for Securing Economy.* The Scientific Press Ltd., London.

Burdett, H. C. (1903). *The Uniform System of Accounts, Audit, and Tenders for Hospitals and Institutions.* The Scientific Press Ltd., London.

Burdett, H. C. (1916). *The Uniform System of Accounts, Audit and Tenders for Hospitals and Institutions*. The Scientific Press Ltd., London.

Byrd, K. F. (1974). A century of professional development. *The Accountant*, pages 431–434.

Canguilhem, G. (1994). *A Vital Rationalist: Selected Writings from Georges Canguilhem*. Zone Books, New York.

Carnegie, G. D. and Edwards, J. R. (2001). The construction of the professional accountant: The case of the incorporated institute of accountants, Victoria (1886). *Accounting, Organizations and Society*, 26:301–325.

Carnegie, G. D. and Napier, C. J. (1996). Critical and interpretive histories: Insights into accounting's present and future through its past. *Accounting, Auditing and Accountability Journal*, 9(3):7–39.

Carrera, N., Guttierrez, I., and Carmona, S. (2001). Gender the state and the audit profession: Evidence from Spain (1942-88). *European Accounting Review*, 10:803–15.

Cassell, R. D. (1990). Lessons in medical politics: Thomas Wakley and the Irish medical charities. *Medical History (Great Britain)*, 34:412–23.

Catford, E. F. (1984). *The Royal Infirmary of Edinburgh 1929-1979*. Scottish Academic Press, 33 Montgomery Street, Edinburgh.

Cavallo, S. (1991). The motivations of benefactors: An overview of approaches to the study of charity. In Barry, J. and Jones, C., editors, *Medicine and Charity Before the Welfare State*, pages 46–62. Routledge, London.

Chandler, A. D. (1962). *Strategy and Structure: Chapters in the History of the Industrial Enterprise*. MIT Press, Cambridge, Mass.

Chandler, A. D. (1977). *The Visible Hand: The Managerial Revolution in American Business*. MIT Press, Cambridge, Mass.

Checkland, O. (1980). *Philanthropy in Victorian Scotland: Social Welfare and the Voluntary Principle*. John Donald, Edinburgh.

Cherry, S. (1996a). Accountability, entitlement, and control issues and voluntary hospital funding c1860-1939. *Social History of Medicine*, 9(2):215–233.

Cherry, S. (1996b). *Medical Services and the Hospitals in Britain 1860-1939*. New Studies in Economic and Social History. Cambridge University Press, Cambridge.

Chua, W. F. (1986). Radical developments in accounting thought. *Accounting Review*, LXI(4):601–632.

Chua, W. F. (1998). Historical allegories: Let us have diversity. *Critical Perspectives on Accounting*, 9:617–628.

Clifford-Smith, J. L. (1883). *Hospital Management: Being the Authorised Report of a Conference on the Administration of Hospitals,Held under the Auspices and Management of the Social Science Association on the 3rd and 4th July 1883*. Kegan Paul, Trench, & Co., London.

Copeman, W. S. C. (1964). The royal hospitals before 1700. In Poynter, F. N. L., editor, *The Evolution of Hospitals in Britain*, pages 27–41. Pitman Medical Publishing Company Ltd., London.

Crawford, C. (1991). A scientific profession: Medical reform and forensic medicine in british periodicals of the early nineteenth century. In French, R. and Wear, A., editors, *British Medicine in an Age of Reform*, pages 203–30. Routledge, USA.

Cunningham, A. and French, R. (1990). *The Medical Enlightenment of the Eighteenth Century*. Cambridge University Press, Cambridge.

Curtis, B. (1995). Taking the state back out: Rose and Miller on political power. *British Journal of Sociology*, Vol 46:575 – 589.

Davie, S. S. K. (2000). Accounting for imperialism: A case of british imposed indigenous collaboration. *Accounting, Auditing and Accountability Journal*, 13:330–59.

Dean, M. (1999). *Govermentality: Power and Rule in Modern Society*. SAGE Publications Ltd, London.

Dedoulis, E. and Caramanis, C. (2007). Imperialism of influence and the state-profession relationship: The formation of the greek auditing profession in the post-WWII era. *Critical Perspectives on Accounting*, 18:393–412.

Dyball, M., Poullaos, C., and Chua, W. F. (2007). Accounting and empire: Professionalisation as resistance - the case of the Phillipines. *Critical Perspectives on Accounting*, 18:415–49.

Edwards, J. R., Anderson, M., and Chandler, R. A. (2007). Claiming a jurisdiction for the 'public accountant' in England prior to organisational fusion. *Accounting, Organizations and Society*, 32:61–100.

Everett, J., Green, G., and Neu, D. (2005). Independence, objectivity and the canadian accounting profession. *Critical Perspectives on Accounting*, 16:415–40.

Everett, S. (1974). Florence Nightingale. *British History Illustrated*, 1:12–25.

Eyler, J. M. (1973). William Farr on the cholera: The sanitarian's disease theory and the statistician's method. *Journal of the History of Medicine & Allied Sciences*, 28:79–100.

Eyler, J. M. (1979). *Victorian Social Medicine: The Ideas and Methods of William Farr*. Johns Hopkins University Press, Baltimore & London.

Ezzamel, M., Hoskin, K., and Macve, R. (1990). Managing it all by numbers: A review of Johnson & Kaplan's "relevance lost". *Accounting and Business Research*, pages 153–166.

Fissell, M. E. (1991). The disappearance of the patient's narrative and the invention of hospital medicine. In French, R. and Wear, A., editors, *British Medicine in an Age of Reform*, pages 92–109. Routledge, USA.

Fleischman, R. K. (2000). Completing the triangle: Taylorism and the paradigms. *Accounting, Auditing & Accountability Journal*, 13(5):597–623.

Fleischman, R. K., Kalbers, L. P., and Parker, L. D. (1996a). Expanding the dialogue: Industrial revolution costing historiography. *Critical Perspectives on Accounting*, 7:315–337.

Fleischman, R. K. and Macve, R. H. (2000). Coals from Newcastle: Alternative paradigms for interpreting the development of cost and management accounting in north-east coal mining during the british industrial revolution. *Paper Presented at the 6th Interdisciplinary Perspectives on Accounting Conference, Manchester, 2000*.

Fleischman, R. K., Mills, P. A., and Tyson, T. N. (1996b). A theoretical primer for evaluating and conducting historical research in accounting. *Accounting History*, 1(1):55–75.

Fleischman, R. K. and Parker, L. D. (1997). *What Is Past Is Prologue: Cost Accounting in the British Industrial Revolution, 1760-1850*. Garland, New York.

Fleischman, R. K. and Radcliffe, V. S. (2000). Divergent streams of accounting history: A review and call for confluence. *Paper Presented at the 6th Interdisciplinary Perspectives on Accounting Conference, Manchester, 2000*.

Fleischman, R. K. and Radcliffe, V. S. (2003). Divergent streams of accounting history: A review and call for con uence. In Fleischman, R. K., Radcliffe, V. S., and Shoemaker, P. A., editors, *Doing Accounting History: Contributions to the Development of Accounting Thought*, pages 31–47. Elsevier Science, Oxford.

Fleischman, R. K. and Tyson, T. N. (2000). Parallels between US and UK cost accountancy in the WWI era. *Accounting, Business and Financial History*, 10:191–212.

Flesher, D. L. and Samson, W. D. (1990). What is publishable accounting history research: An editorial view. *The Accounting Historians Journal*, 17(1):1–4.

Foucault, M. (1973). *The Birth of the Clinic*. Tavistock Press, London.

Foucault, M. (1977). *Discipline and Punish*. Allen Lane, London.

Foucault, M. (1979). On governmentality. In Burchell, G., Gordon, C., and Miller, P., editors, *The Foucault Effect: Studies in Govermentality*. Harvester Wheatsheaf, London.

Foucault, M. (1991). Governmentality. In Graham Burchell, C. G. and Miller, P., editors, *The Foucault Effect: Studies in Governmentality*, pages 87–104. Harvester Wheatsheaf, London.

Foucault, M. (1997). What is critique? In Lotringer, S. and Hochroth, L., editors, *The Politics of Truth*, pages 23–82. semio-text(e), New York.

Froud, J., Haslam, C., Johal, S., and Williams, K. (2000). Representing the household: In and after national income accounting. *Accounting, Auditing and Accountability Journal*, 13(4):535–560.

Funnell, W. (1996). Preserving history in accounting: Seeking common ground between "new" and "old" accounting history. *Accounting, Auditing and Accountability Journal*, 9:38–64.

Funnell, W. (1998). The narrative and its place in the new accounting history: The rise of the counter narrative. *Accounting, Auditing and Accountability Journal*, 11(2):142–162.

Funnell, W. (2001). Distortions of history, accounting and the paradox of werner sombart. *Abacus*, 37(1):55–78.

Gaffikin, M. (1998). History is dead, long live history. *Critical Perspectives on Accounting*, 9:631–639.

Gallhofer, S. and Haslam, J. (1994a). Accounting and the Benthams - or accounting's potentialities. *Accounting, Business and Financial History*, 4(3):431–461.

Gallhofer, S. and Haslam, J. (1994b). Accounting and the Benthams: Accounting as negation? *Accounting, Business and Financial History*, 4(2):239–273.

Gallhofer, S. and Haslam, J. (1996). Analysis of Bentham's chrestomathia: or, towards a critique of accounting education. *Critical Perspectives on Accounting*, 7(1/2):13–31.

Gallhofer, S. and Haslam, J. (2000). Bentham, accounting and critical theory: Encounters in a critical theoretical reading. *Paper Presented at the Sixth Interdisciplinary Perspectives on Accounting Conference, Manchester, 2000*.

Gamgee, S. (1868). Hospital reform: Revised report of a speech, delivered at the general meeting of the medico-political association, held in Birmingham, april 17, 1868.

Gibson, H. J. C. (1948). *The Story of the Old Infirmary: With a Short Account of More Recent Years*. William Kidd & Sons, Ltd.

Gilbert, H. (1977). King Edward's Hospital Fund for London: The first 25 years. *Social and Economic Administration*, Vol. 8:43–63.

Goldberg, L. (1957). Jeremy Bentham: Critic of accounting method. *Accounting Research*, 8:218–45.

Goldman, M. (1987). *Lister Ward*. Adam Hilger, Bristol.

Gordon, C. (1991). Governmental rationality: An introduction. In Graham Burchell, C. G. and Miller, P., editors, *The Foucault Effect: Studies in Governmentality*, pages 1–51. Harvester Wheatsheaf, London.

Gorelik, G. (1973). Notes on the development and problems of soviet uniform costing. *The International Journal of Accounting*, 9(Fall):135–148.

Granshaw, L. (1990). Fame and fortune by means of bricks and mortar. In Granshaw, L. and Porter, R., editors, *The Hospital in History*, pages 199–220. Routledge, London.

Granshaw, L. (1992). The rise of the modern hospital in britain. In Wear, A., editor, *Medicine in Society: Historical Essays*, pages 197–218. Cambridge University Press, Cambridge.

Greenwood, M. (1948). *Medical Statistics from Graunt to Farr*. Cambridge University Press, Cambridge.

Hacking, I. (1990). *The Taming of Chance*. Cambridge University Press, Cambridge, England.

Hall, J. M. and Harral, V. C. (1967). *The General Hospital, Birmingham*. U. B. H., Birmingham.

Halliday, S. (2000). William Farr: Campaigning statistician. *Journal of Medical Biography*, 8:220–7.

Hamilton, D. (1988). The scottish enlightenment and clinical medicine. In Dow, D. A., editor, *The Influence of Scottish Medicine: An Historical Assessment of its International Impact*, pages 103–112. Parthenon, Carnforth.

Hamlin, C. (1994). State medicine in great britain. In Porter, D., editor, *The History of Public Health and the Modern State*, The Wellcome Institute Sreies in the History of Medicine, chapter 3, pages 132–164. Editions Rodopi BV, Amsterdam.

Hammond, T. D. (1997). From complete exclusion to minimal inclusion: African americans and public accounting industry, 1965-1988. *Accounting, Organizations and Society*, 22(1):29–53.

Hart, H. W. (1980). Some notes on the sponsoring of patients for hospital treatment under the voluntary system. *Medical History*, 24:447–460.

Henry, A. (1869). Hospital administration. *The Lancet*, 1:272.

Hernandez-Esteve, E. (1994). Comments on some obscure or ambiguous points of the treatise (de computis et scripturis) by luca pacioli. *The Accounting Historians Journal*, 21:17–80.

Holden, A., Funnell, W., and Oldroyd, D. (2007). Accounting and the moral economy of illness in victorian England: The Newcastle Infirmary. *Accounting, Auditing and Accountabilty*, 22.

Hopper, T. and Armstrong, P. (1991). Cost accounting, controlling labour and the rise of conglomerates. *Accounting, Organisations and Society*, 16(5/6):405–438.

Hopwood, A. G. (1987). The archaeology of accounting systems. *Accounting, Organisations and Society*, 12(3):207–234.

Hopwood, A. G. (1994). Accounting in everyday life: An introduction. *Accounting, Organizations and Society*, 19(3):299–301.

Hoskin, K. and Macve, R. (1988a). Cost accounting and the genesis of managerialism: The Springfield armoury episode. *paper presented at the Second Interdisciplinary Perspectives on Accounting Conference, Manchester*.

Hoskin, K. and Macve, R. (1988b). The genesis of accountability: The West Point connections. *Accounting, Organizations and Society*, 13(2):37–73.

Hoskin, K. and Macve, R. (1994). Reappraising the genesis of managerialism: A re-examination of the role of accounting at the Springfield armoury, 1815-1845. *Accounting, Auditing and Accountability Journal*, 7(1):4–29.

Hoskin, K. and Macve, R. (1996). The lawrence manufacturing co.: A note on early cost accounting in US textile mills. *Accounting, Business and Financial History*, 6(3):337–361.

Hoskin, K. and Macve, R. (2000). Knowing more as knowing less? alternative histories of cost and management accounting in the US and the UK. *Accounting Historians Journal*, 27(1):91–149.

Hoskin, K. W. and Macve, R. H. (1986). Accounting and the examination: A genealogy of disciplinary power. *Accounting, Organisations and Society*, 11(2):105–136.

Hostettler, J. (1984). Thomas Wakley – an enemy of injustice. *Journal of Legal History*, 5:60–75.

Howie, W. B. (1963). Finance and supply in an eighteenth-century hospital, 1747-1830. *Medical History*, 7:126–146.

Hume, D. (1997). Morality and benevolence. In Broadie, A., editor, *The Scottish Enlightenment: An Anthology*, pages 143–154. Canongate Classics, Edinburgh.

Hume, L. J. (1970). The development of industrial accounting: The Bentham's contribution. *Journal of Accounting Research*, 8(1):21–33.

Humphreys, N. A. (1885). *Vital Statistics: A Memorial Volume of Selections from the Reports and Writings of William Farr*, chapter Preface. The Sanitary Institute, London.

Hutcheson, F. (1997). Concerning moral good and evil. In Broadie, A., editor, *The Scottish Enlightenment: An Anthology*, pages 119–142. Canongate Classics, Edinburgh.

Jeacle, I. (2003). Accounting and the construction of the standard body. *Accounting, Organizations and Society*, 28:357–377.

Jeacle, I. (2006). Face facts: Accounting, feminism and the business of beauty. *Critical Perspectives on Accounting*, 17:87–108.

Jeacle, I. (2009). 'going to the movies': Accounting and 20th century cinema. *Accounting, Auditing and Accountability*, forthcoming.

Johnson, H. T. (1972). Early cost accounting for internal management control: Lyman Mills in the 1850s. *Business History Review*, 46(Winter):466–74.

Johnson, H. T. (1983). The search for gain in markets and firms: A review of the historical emergence of management accounting systems. *Accounting, Organisations and Society*, 8(2/3):139–146.

Johnson, H. T. and Kaplan, R. S. (1987). *Relevance Lost: The Rise and Fall of Management Accounting*. Harvard University Press, Boston, Mass.

Jones, M. J. and Mellet, H. J. (2007). Determinants of change in accounting practices: Accounting and the UK health service. *Critical Perspectives on Accounting*, 18:91–121.

Jones, M. J. and Mellett, H. J. (2000). Determinants of changes in accounting practice: Accounting and the health service. *Paper Presented at the Sixth Interdisciplinary Perspectives on Accounting Conference, Manchester, 2000*.

King, G. (1849). *Uniformity of Railway Accounts: A Few Remarks Elucidatory and Suggestive on the Subject of Railway Economy: Also, Proposal of a Method of Keeping Railway Accounts of One Uniform Plan, And of Closing Capital Accounts in a Way That Shall Encroach Unduly Upon Present Dividends*. E. F. Gooch, London.

Kirkham, L. M. and Loft, A. (2001). The lady and the accounts: Missing from accounting history? *Accounting Historians Journal*, 28(1):67–90.

Komori, N. and Humphrey, C. (2000). From an envelope to a dream note and a computer: The award-winning experiences of post-war Japanese household accounting practices. *Accounting, Auditing & Accountability Journal*, 13(4):450–474.

Lacombe-Saboly, M. (1997). Hospital accounts and accounting systems: A study in the french region of Toulouse from the seventeenth to the nineteenth century. *Accounting, Business and Financial History*, 7(3):259–280.

Lamb, M. (2001). 'horrid appealing': Accounting for taxable profits in mid-19th century England. *Accounting, Organizations and Society*, 26:271–298.

Lapsley, I. and Robbins, G. (2008). Irish voluntary hospitals: An examination of a theory of voluntary failure. *Accounting, Business and Financial History*, 18.

Lee, G. A. (1973a). The development of Italian bookkeeping. *Abacus*, 9:137–155.

Lee, G. A. (1973b). The Florentine bank ledger fragments of 1211: Some new insights. *Journal of Accounting Research*, 11(Spring).

Leonard, P. (1997). *Postmodern Welfare: Reconstructing an Emancipatory Project*. Sage, London.

Littleton, A. C. (1933). *Accounting Evolution to 1900*. American Institute Publishing Company, New York.

Llewellyn, S. and Walker, S. P. (2000). Household accounting as an interface activity: The home, the economy and gender. *Critical Perspectives on Accounting*, 11:447–478.

Loft, A. (1986). Towards a critical understanding of accounting: The case of cost accounting in the UK, 1914-1925. *Accounting, Organisations and Society*, 11(2):137–169.

Loft, A. (1995). The history of management accounting: Relevance found. In Ashton, D., Hopper, T., and Scapens, R. W., editors, *Issues in Management Accounting*, pages 21–44. Prentice Hall, London, 2nd edition.

Logan Turner, A. (1929). *Story of a Great Hospital: The Royal Infirmary of Edinburgh 1729-1929*. James Thin, Edinburgh.

MacDonald, K. M. (1984). Professional formation: The case of scottish accountants. *British Journal of Sociology*, 35(2):174–89.

MacDonald, K. M. (1987). Professional formation: A reply to briston and kedsley. *British Journal of Sociology*, 38(1):106–111.

Maddox, I. (1743). *The Duty and Advantages of Encouraging Public Infirmaries*. J. Brotherton, London.

McMenemey, W. H. (1964). The hospital movement of the eighteenth century and its development. In Poynter, F. N. L., editor, *The Evolution of Hospitals in Britain*, pages 43–72. Pitman Medical Publishing Company Ltd, London.

Merino, B. D. (1998). Critical theory and accounting history: Challenges and opportunities. *Critical Perspectives on Accounting*, 9:603–616.

Merino, B. D. and Mayper, A. G. (1993). Accounting history and empirical research. *The Accounting Historians Journal*, 20(2):237–267.

Michelli (1888). Hospital extravagance and expenditure. *The Lancet*, 2:1241–2.

Miller, P. (1992). Accounting and objectivity: The invention of calculating selves and calcuable spaces. *Annals of scholarship*, Vol 9(1/2):61–96.

Miller, P. (1994). Accounting as social and institutional practice:an introduction. In Hopwood, A. G. and Miller, P., editors, *Accounting As Social and Institutional Practice*, pages 1–39. Cambridge, Cambridge.

Miller, P., Hopper, T., and Laughlin, R. (1991). The new accounting history: An introduction. *Accounting, Organisations and Society*, 16(5/6):395–403.

Miller, P. and O'Leary, T. (1987). Accounting and the construction of the governable person. *Accounting, Organisations and Society*, 12(3):235–266.

Miller, P. and Rose, N. (1988). The tavistock programme: The government of subjectivity and social life. *Sociology*, Vol 22(2):171–192.

Miller, P. and Rose, N. (1990). Governing economic life. *Economy and Society*, 19(1):1–31.

Miller, P. and Rose, N. (1995a). Political thought and the limits of orthodoxy: A response to curtis. *British Journal of Sociology*, Vol 46:590–597.

Miller, P. and Rose, N. (1995b). Production, identity and democracy. *Theory and society*, Vol 24:427–467.

Millman, M. (1974). The influence of the social science association on hospital planning in victorian england. *Medical History*, 18:122–37.

Mitchell, F. and Walker, S. P. (1997). Market pressures and the development of costing practice: The emergence of uniform costing in the u.k. printing industry. *Management Accounting Research*.

Morrell, J. B. (1971). The university of edinburgh in the late eighteenth century: Its scientific eminence and academic structu. *Isis*, 62:158–71.

Morrell, J. B. (1972). Science and scottish university reform: Edinburgh in 1826. *British Journal for the History of Science*, 21:39–56.

Morris, E. W. (1910). *A History of the London Hospital*. Edward Arnold, London.

Morris, H. (1905). The financial relations between the london hospitals and their medical schools; and the bearing of these relations on medical education. *The Lancet*, pages 1313–19.

Most, K. S. (1961). *Uniform Cost Accounting and the Classification and Coding of Accounts*. Gee, London.

Most, K. S. (1972). Sombart's propositions revisited. *The Accounting Review*, 47.

Most, K. S. (1976). How wrong was sombart? *The Accounting Historians Journal*, 3:22–28.

Mouat, F. J. (1881). On hospitals: Their management, construction, and arrangements in relation to the successful treatment of disease, with remarks on the organisation of medical relief in the metropolis. *The Lancet*, pages 78–82.

Mouat, F. J. and Saxon-Snell, H. (1883). *Hospital Construction and Management*. J & A Churchill & Co., London.

Napier, C. J. (1989). Research directions in accounting history. *British Accounting Review*, 21:237–254.

Napier, C. J. (2006). Accounts of change: 30 years of historical accounting research. *Accounting, Organizations and Society*, 31:445–507.

Neu, D. (1999). "discovering" indigenous peoples: Accounting and the machinery of empire. *Accounting Historians Journal*, 26(1):53–82.

Neu, D. (2000). "presents" for the "indians": Land, colonialism and accounting in canada. *Accounting, Organizations and Society*, 25:163–184.

Neu, D. and Graham, C. (2006a). Accounting and the holocausts of modernity. *Accounting, Auditing and Accountability Journal*, 17:47–76.

Neu, D. and Graham, C. (2006b). The birth of a nation: Accounting and canada's first nations. *Accounting, Organizations and Society*, 31:47–76.

Neu, D. and Therrien, R. (2003). *Accounting for Genocide: Canada's Bureaucratic Assault on Aboriginal People*. Zed Books, London.

Newman, C. (1964). The hospital as a teaching centre. In Poynter, F. N. L., editor, *The Evolution of Hospitals in Britain*, pages 187–205. Pitman Medical Publishing Company Ltd, London.

Newmarch, F. (1869). Hospital expenditure. *The Lancet*, 2:831.

Nightingale, F. (1858). *Notes on Matters Affecting the Health, Efficiency, and Hospital Administration of The British Army, Founded Chiefly on the Experience of the Late War*. Harrison & Sons, London.

Nightingale, F. (1863). *Notes on Hospitals*. Longman, Green, Longman, Roberts and Green, London, 3rd edition.

Nobes, C. W. (1982). The gallerani account book of 1305-1308. *The Accounting Review*, 57:303–370.

of Inquiry Into the Funding of Medical Schools, K. F. C. (1905). The financial relations between hospitals and medical schools. Technical report, The Kings Fund.

Owen, D. (1965). *English Philanthropy 1660-1960*. Belknap Press, Cambridge Massachusetts.

Parker, L. D. (1997). Informing historical research in accounting and management: Traditions, philosophies, and opportunities. *The Accounting Historians Journal*, 24(2):111–149.

Pickstone, J. V. and Butler, S. V. F. (1984). The politics of medicine in manchester, 1788-1792: Hospital reform and public health services in the early industrial city. *Medical History*, 28:227–249.

Pinker, R. (1966). *English Hospital Statistics, 1861-1938*. Heinemann, London.

Porter, D. and Porter, R. (1989). *Patient's Progress: Doctors and Doctoring in Eighteenth Century England*. Polity, Cambridge.

Porter, R. (1982). Was there a medical enlightenment in eighteenth-century england? *British Journal for Eighteenth Century Studies*, 5:49–63.

Porter, R. (1989). The gift relation: Philanthropy and the provincial hospitals in eighteenth-century england. In Granshaw, L. and Porter, R., editors, *The Hospital in History*, pages 149–178. Routledge, London.

Porter, R. (1993). *Disease, Medicine and Society in England, 1550-1860*. New Studies in Economic and Social History. Cambridge University Press, The Edinburgh Building, Cambridge, CB2 2RU, second edition.

Porter, R. (1997). *The Greatest Benefit to Mankind: A Medical History of Humanity from Antiquity to the Present*. HarperCollins, London.

Porter, R. and Porter, D. (1988). *In Sickness and in Health: The British Experience 1650-1850*. Fourth Estate, London.

Porter, T. M. (1996). *Trust in Numbers: The Pursuit of Objectivity in Science and Public Life*. Princeton University Press.

Poullaos, C. (1998). Telling stories about accounting history. *Critical Perspectives on Accounting*, 9:701–710.

Preston, A. (2006). Enabling, enacting and maintaining action at a distance: An historical case study of the role of accounts in the reduction of the navajo herds. *Accounting, Organisations and Society*, 31:559–78.

Preston, A. and Oakes, L. (2001). The navajo documents: A study of the economic representation and construction of the navajo. *Accounting, Organisations and Society*, 26:39–71.

Preston, A. M. (1992). The birth of clinical accounting: A study of the emergence and transformations of discourses on costs and practices of accounting in u.s. hospitals. *Accounting, Organisations and Society*, 17(1):63–100.

Preston, A. M., Chua, W.-F., and Neu, D. (1997). The diagnosis-related group-prospective payment system and the problem of the government of rationing health care to the elderly. *Accounting, Organizations and Society*, 22(2):147–164.

Preston, C. I. (1840). *A Practical Treatise on Accounts, Mercantile, Private, and Official: Exhibiting the Manner in Which the Method of Double Entry May Be Applied To the Accounts of Government, With Proposals for the Introduction of a Uniform and Centralised System of Accounts in All the Public Offices*. W. Pickering, London.

Previts, G. J., Parker, L. D., and Coffman, E. N. (1990). Accounting history: Definition and relevance. *Abacus*, 26(1):1–13.

Prochaska, F. K. (1992). *Philanthropy and the Hospitals of London: The King's Fund 1897 - 1990*. Oxford University Press, Oxford.

Ramirez, C. (2001). Understanding social closure in its cultural context: Accounting practitioners in france (1920-1939). *Accounting, Organizations and Society*, 26:391–418.

Risse, G. B. (1986). *Hospital Life in Enlightenment Scotland: Care and Teaching at the Royal Infirmary of Edinburgh*. Cambridge University Press.

Rivett, G. (1986). *The Development of the London Hospital System*. King Edwards Hospital Fund for London, London.

Roberts, J. (1991). The possibilities of accountability. *Accounting, Organizations and Society*, 16(4):355–368.

Roberts, J. and Scapens, R. (1990). Accounting as discipline. In Cooper, D. J. and Hopper, T. M., editors, *Critical Accounts*, pages 107–126. MacMillan, London.

Robson, N. (2003). From voluntary to state control and the emergence of the department in the UK hospital. *Accounting, Business & Financial History*, 13:99–123.

Robson, N. (2007). The road to uniformity: Accounting change in UK voluntary hospitals 1880-1920. *Accounting & Business Research*, 36:271–88.

Rodgers, B. (1949). *Cloak of Charity. Studies in Eighteenth Century Philanthropy*. Methuen, London.

Rose, N. and Miller, P. (1992). Political power beyond the state: Problematics of government. *British Journal of Sociology*, Vol 43:173–205.

Rosenberg, C. E. (1979). *Healing and History: Essays for George Rosen*, chapter Florence Nightingale on Contagion: The Hospital as Moral Universe, pages 116–136. Science History, New York.

Rosenberg, C. E. (1981). Medicine community in victorian britain. *Journal of Interdisciplinary History*, XI:677–84.

Scholnick, R. J. (1999). The fiery cross of knowledge: Chambers's edinburgh journal. *Victorian Periodicals Review*, 32:324–58.

SCMH (1892). *Third Report from the Select Committee of the House of Lords on Metropolitan Hospitals*. HMSO, London.

Scrivenor, H. (1849). *The Railways of the United Kingdom, Statistically Considered: Together with the Railway Accounts, Rendered Upon a Uniform Plan.* Smith, Elder, and Co., London.

Scrivenor, H. (1851). *The Railways of the United Kingdom Statistically Considered in Relation to Their Extent, Capital, Amalgamations, Debentures, Financial Position, Acts of Parliament by Which Regulated, Creation and Appropriation of Shares, Calls, Dividends, and Various Other Minor Particulars, Together with the Railway Accounts, Rendered Upon a Uniform Plan.* Smith, Elder, and Co., London.

Seville, M. A. (1987). The evolution of voluntary health and welfare organization accounting: 1910 - 1985. *The Accounting Historians Journal*, 14(1):57–82.

Shackleton, K. (1999). Gender segregation in scottish chartered accountancy: The deployment of male concerns about the admission of women, 1900-1925. *Accounting, Business & Financial History*, 9(1):135–56.

Sian, S. (2006). Inclusion, exclusion and control: The case of the kenyan accounting professionalisation project. *Accounting, Organizations and Society*, 31:295–322.

Slater, V. E. (1994). The educational and philosophical influences on florence nightingale, an enlightened conductor. *Nursing History Review*, 2:137–52.

Small, H. (1999). *Florence Nightingale: Avenging Angel.* Constable, London.

Solomons, D. (1950a). Uniform cost accounting - a survey, part ı. *Economica*, August:237–253.

Solomons, D. (1950b). Uniform cost accounting - a survey, part ıı. *Economica*, November:386–400.

Solomons, D. (1991). Accounting and social change: A neutralist view. *Accounting, Organizations and Society*, 16(3):287–295.

Sombart, W. (1924). *Der Moderne Kapitalismus.* Durcher and Humboldt, Leipzig, 6th edition.

Steedman, J. (1778). *The History and Statutes of the Royal Infirmary of Edinburgh.* Balfour and Smellie, Edinburgh.

Stewart, R. E. (1992). Pluralising our past: Foucault in accounting history. *Accounting, Auditing & Accountability Journal*, 5(2):57–73.

Stokes, T. N. (1989). A coleridgean against the medical corporations: JohnSimon and the parliamentary campaign for the reform of the MedicalProfession 1854-8. *Medical History*, 33:343–59.

Strachey, L. (1918). *Eminent Victorians*. William Clowes & Sons, Ltd, London.

Sturdy, S. and Cooter, R. (1998). Science, scientific management, and the transformation of medicine in britain *c.* 1870-1950. *History of science*, xxxvi:421–466.

Suzuki, T. (2001). The epistemology of macroeconomic reality: The keynesian revolution from an accounting point of view. *Paper Presented in the Arthur Andersen Seminar Series at the University of Edinburgh on the 26th October 2001.*

Szreter, S. (1991). Introduction: The GRO and the historian. *Social History of Medicine*, 4:401–14.

Thin, R. (1927). The old infirmary and earlier hospitals. *the Book of the Old Edinburgh Club*, 15:133–163.

Tinker, T. and Neimark, M. (1988). The struggle over meaning in accounting and corporate research: A comparative evaluation of conservative and critical historiography. *Accounting, Auditing and Accountability Journal*, 1(1):55–74.

Trail, R. R. (1964). The history of hospital finance and administration. In Poynter, F. N. L., editor, *The Evolution of Hospitals in Britain*, pages 231–243. Pitman Medical Publishing Company Ltd, London.

Tyson, T. (1990). Accounting for labour in the early 19th-century: The US arms making experience. *The Accounting Historians Journal*, 17:47–59.

Tyson, T. (1993). Keeping the record straight: Foucauldian revisionism and nineteenth century US cost accounting history. *Accounting, Auditing and Accountability Journal*, 6(1):4–16.

Tyson, T., Oldroyd, D., and Fleischman, R. (2005). Accounting, coercion and social control during apprenticeship: Converting slave workers to wage workers in the british west indies, c.1834-1838. *Accounting Historians Journal*, 32:201–31.

Tyson, T. N. (1998). Mercantilism, management accounting or managerialism? cost accounting in early nineteenth-century US textile mills. *Accounting, Business and Financial History*, 8(2):211–229.

Tyson, T. N. (2000). Accounting history and the emperor's new clothes: A response to "knowing more as knowing less". *Accounting Historians Journal*, 27(1):159–171.

Underhill, P. (1992). Alternative views of science in intra-ProfessionalConflict: General practitioners and the medical and surgical elite 1815-58. *Journal of Historical Sociology*, 5:322–50.

Van Peursem, K. A., Pratt, M. J., and Tower, G. (1996). Reporting for the new zealand health sector: A history of public or private interest? *Accounting, Business and Financial History*, 6(2):183–201.

Varma, S. and Gray, S. J. (2006). The creation of the institute of chartered accountants of india: The first steps in the development of an indigenous accounting profession post-independence. *Accounting Historians Journal*, 33:131–56.

Vent, G. and Milne, R. A. (1989). The standardization of mine accounting. *The Accounting Historians Journal*, 16(1):57–74.

Waddington, I. (1973). The struggle to reform the royal college of physicians, 1767-1771: A sociological analysis. *Medical History*, 17:107–126.

Waddington, I. (1984). *The Medical Profession in the Industrial Revolution*. Gill and Macmillan, Dublin.

Waddington, K. (1995). Bastard benevolence: Centralisation, voluntarism and the sunday fund 1873-1898. *London Journal*, 19:151–167.

Waddington, K. (1998). Unsuitable cases: The debate over outpatient admissions, the medical profession and late-victorian london hospitals. *Medical History*, 42:26–46.

Waddington, K. (2000). *Charity and the London Hospitals, 1850-1898*. The Royal Historical Society, London.

Walker, S. P. (1991). The defence of professional monopoly: Scottish chartered accountants and "satellites in the accountancy firmament" 1854-1914. *Accounting, Organizations and Society*, Vol. 16(3):257–285.

Walker, S. P. (1995). The genesis of professional organization in scotland: a contextual analysis. *Accounting, Organizations and Society*, 20(4):285–310.

Walker, S. P. (1998). How to secure your husband's esteem. accounting and private patriarchy in the british middle class household during the nineteenth century. *Accounting, Organizations and Society*, 23(5/6):485–514.

Walker, S. P. (2000). Encounters with nazism: British accountants and the fifth international congress on accounting. *Critical Perspectives on Accounting*, 11:215–245.

Walker, S. P. (2003a). Agents of disposession and aculturation. edinburgh accountants and the highland clearances. *Critical Perspectives on Accounting*, 14:813–53.

Walker, S. P. (2003b). Identifying the woman behind the 'railed-in desk': The proto-feminisation of bookkeeping in britain. *Accounting, Auditing and Accountability Journal*, 16:606–39.

Walker, S. P. (2003c). Professionalisation or incarceration? household engineering, accounting and the domestic ideal. *Accounting, Organizations and Society*, 28:743–72.

Walker, S. P. (2004a). Conflict, collaboration, fuzzy jurisdictions and partial settlements. accountants, lawyers and insolvency practice during the late nineteenth century. *Accounting and Business Research*, 34:247–65.

Walker, S. P. (2004b). Expense, social and moral control: Accounting and the administration of the old poor law in england and wales. *Journal of Accounting and Public Policy*, 23:85–127.

Walker, S. P. (2004c). The genesis of professional organisation in english accountancy. *Accounting, Organizations and Society*, 29(2):127–156.

Walker, S. P. (2004d). *Towards the 'Great Desideratum': The Unification of the Accountancy Bodies in England 1870-1880*. ICAS, Edinburgh.

Walker, S. P. (2008). Accounting, paper shadows and the stigmatised poor. *Accounting, Organizations and Society*, 33:453–87.

Walker, S. P. and Carnegie, G. (2007). Budgetary earmarking and the control of the extravagant woman in australia. *Critical Perspectives on Accounting*, 18:233–61.

Walker, S. P. and Mitchell, F. (1996). Propaganda, attitude change and uniform costing in the british printing industry, 1913-1939. *Accounting, Auditing and Accountability Journal*, 9(3):98–126.

Walker, S. P. and Mitchell, F. (1998). Labour and costing: The employees' dilemma. *Accounting Historians Journal*, 25(2):35–62.

Walker, S. P. and Shackleton, K. (1995). Corporatism and structural change in the british accountancy profession, 1930-1957. *Accounting, Organizations and Society*, 20(6):467–503.

Warner, J. H. (1991). The idea of science in english medicine: The 'decline of science' and the rhetoric of reform, 1815-45. In French, R. and Wear, A., editors, *British Medicine in an Age of Reform*, pages 136–64. Routledge, USA.

Wear, A. (1992). The popularization of medicine in early modern england. In Porter, R., editor, *The Popularization of Medicine 1650-1850*, pages 17–41. Routledge.

Wilde, J. (1810). *The Hospital: A Poem in Three Books*. Stevenson, Matchett & Stevenson, Norwich, England.

Williamson, O. E. (1975). *Markets and Hierarchies: Analysis and Antitrust Implications: A Study in the Economics of Internal Organization*. Collier Macmillan, New York.

Willmott, H. (1986). Organising the profession: A theoretical and historical examination of the development of the major accountancy bodies in the UK. *Accounting, Organizations and Society*, 11(6):555–580.

Winchester County Hospital (1737). An account of the establishment of the county hospital at winchester, with the proceedings of the governors, &c. from the first institution on st luke's day, october 18, 1736, michaelmas, 1737. pages 149–152. Reprinted in: Woodward J., (1974), *To Do the Sick No Harm*, Routledge & Kegan Paul, London.

Wohl, A. (1984). *Endangered Lives: Public Health in Victorian Britain*. Methuen, London.

Woodham-Smith, C. (1952). *Florence Nightingale 1820-1910*. The Reprint Society, London.

Woodward, J. (1974). *To Do the Sick No Harm: A Study of the British Voluntary Hospital System to 1875*. Routledge & Kegan Paul, London.

Worthington, B. (1895). *Professional Accountants*. Gee & Co.

Yamey, B. S. (1949). Scientific bookkeeping and the rise of capitalism. *The Economic History Review*, pages 99–113.

Yule, B. (1999). *Matrons, Medics and Maladies: Edinburgh Royal Infirmary in the 1840s*. Tuckwell Press, The Mill House, Phantassie, East Linton, East Lothian, EH40 3DG, Scotland.